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THE SOCIAL HEALTH MAINTENANCE ORGANIZATION(S/HMO) :
CAN IT SERVICE THE NEEDS OF RIVERSIDE COUNTY'S ELDERLY?

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Science
in
Health Services Administration

by
Allen Dillard Jaszcar
March 1994


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March 1994

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ABSTRACT

The Social Health Maintenance Organization(S/HMO): Can it service the needs of Riverside County's elderly?

America's elderly population, that portion of the population that is 65 years of age or older, is experiencing a health care crisis. The effects of the aging process places financial, administrative, and social burdens on the health care system of our country as seen in the increased demand for long-term services, home health care and community services related to homemaker services, etc and support for other activities of daily living(ADLs).

The following trends and projections depict the age, social, health, and economic profile of 4.2 million older Californians: 8 percent are homebound; 21 percent have one or more chronic disabilities; 15 percent cannot perform one or more basic ADLs; 30 percent live alone; 15 percent with children, relatives or friends; 54percent live with a spouse; and 80 percent of care giving for impaired elderly is performed by family members.

A needs assessment of the elderly conducted by the Riverside County Area Office on Aging found that the elderly want and need the following health care services: expanded in-home health care; in-patient discharge planning that sets up home health care services; treatment for substance abuse and depression; and expansion of preventive health programs.

One alternative to providing these services is the Social Health Maintenance Organization (S/HMO). A S/HMO, in support and expansion of an HMO TEFRA Medicare Risk Contract, can provide those chronic care expanded services that allow the elderly to remain at home as long as possible. Chronic care services provided by an S/HMO include case management, Skilled Nursing Facility(SNF)and Intermediate Care Facility(ICF) coordination, home health homemaker services, and other community-based in-home services. The S/HMO long-term benefit structure provides longer and more intensive post-acute care, ongoing monitoring and service for the medically complex and unstable, long-term support for ADLs, and short-term nursing home stays for convalescence, respite, and other purposes.

THESIS QUESTION

What is the feasibility of planning and implementing a Social Health Maintenance Organization in Riverside County, for a large Health Maintenance Organization, to provide acute, chronic and expanded health care services for the county's elderly population.

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GLOSSARY

AAPCC. Average Annual Per Capita Cost computed by HCFA for Medicare Reimbursement. This is the Average Annual Per Capita Cost of the Fee-for-Service sector of health care, generally computed at county level with adjustments made for age, sex, institutional status, and welfare status. HCFA reimburses HMOs at 95percent of this computed rate prospectively on a monthly basis.

ADL. Activities of Daily Living. Generally includes eating, Toileting, dressing, bathing, walking, getting in and out of bed or chair, and getting outside.

Alzheimer's disease. Irreversible dementia which occurs in adults. Characterized by intellectual impairment such as confusion, disorientation, delirium and forgetfulness.

Arthritis. A disease of the joints which causes inflammation and stiffening of the joints.

Dementia. Organic loss of mental functioning. A partial or complete loss of the mind.

FTE. Full Time Equivalent Employee. An FTE of 1.0 means that the position is paid at 40 hours per week, generally with no replacement for sick-leave or vacation. A 1.2 FTE is replaced when sick or on vacation. A 1.6 FTE is replaced on days-off, vacations, and sick-leave.

HCFA. Health Care Financing Administration. Responsible for regulations and policies related to payments for the nation's health care programs and Medicare. Part of the Department of Health and Human Services.

IADL. Instrumental Activities of Daily Living. Generally includes preparing meals, shopping, managing money, using the telephone, light housework, and heavy housework.

ICC. Impairment Classification Criteria. Used by the S/HMO sites to determine Chronic Benefit Eligibility. Severe Functional Impairment, bedridden and one or more ADL limitations. Moderate Functional Impairment, Three or more ADL limitations and/or two or more IADL limitations, problems with memory loss or use a wheelchair or walker. Unimpaired, All those identified as severely or moderately impaired.

ICF. Intermediate Care Facility. An institution licensed to provide health related care and services to patients who do not require acute care but require assistance with some ADLs or IADLs on a temporary basis.

Incontinence. A loss of control of either the bladder or the bowel or both.

Morbidity. The extent of illness, injury, or disability in a defined population. The morbidity rate is the ratio of the number of persons ill in a certain population.¹

NHC. Nursing Home Certifiable. If the member is found to be living in the community "at risk" of institutionalization as measured by state pre-admission screening protocols, they receive an institutional rate of payment from HCFA. (See ICC for guidelines)

Osteoporosis. A disorder most common among those elderly in long-term care. Generally due to the aging process and complicated by a decrease in protein and minerals in the diet.²

Parkinson's disease. Characterized by rhythmic muscular tremors known as pill rolling, accompanied by spasticity and rigidity of movement, propulsive gait, droopy posture, and mask-like facial expression.³

Queuing. A method used to control adverse selection. In the case of the S/HMO demonstration project, the ability to guard against enrolling a larger percentage of functionally -impaired members than in the aged population of the market area. The S/HMO could place a member, based on the applicants functional impairment (severe, moderate, or unimpaired), in que for membership in order to maintain the community average.

SNF. Skilled Nursing Facility. Provides skilled nursing services in a long-term care setting, generally not exceeding 100 days, in order to provide rehabilitation and convalescence services for previously hospitalized patients.

To Priscilla my wife for her love and support and my
daughters Jennifer and Melanie for their patience.

CHAPTER I

INTRODUCTION

America's elderly population, that portion of the population that is 65 years of age or older, is experiencing a health care crisis. The increased growth of the elderly segment of our population has greatly impacted the health care system. The effects of this are readily seen in the increasing need for long-term care services, home health care and community services available to serve the needs of the elderly. Increased age brings frailty and the need for services such as housing, meals, in-home care and transportation to help reduce inappropriate institutionalization of the elderly. Among those 85 and older, we can expect an increased need for a variety of those supportive services that help individuals remain in their homes and neighborhoods, where they want to be.⁴ More than 9 out of 10 people receiving home care assistance report an improved quality of life.....⁵

The nation's 65+ population is projected to grow rapidly over the next 50 years as the "Baby Boom" generation ages (Appendix A, "65+ Population Projection(National): 1995-2075"). The elderly over age 85 comprise the fastest growing sub-group of our nation's population. Between 1980 and 2030 it is projected that the number of these oldest old

will quadruple from 2.2 million to 8.6 million.⁶ This projection is also supported by data available from the 1990 Community Service Area (CSA) census data that shows that Riverside County has experienced a 51 percent increase in total population aged 60+ within the last decade. The county's aged 75+ population increased 80 percent during that same period and the segment of the county's population experiencing the greatest growth rate are individuals aged 85+ which grew 77 percent in the last decade compared to 37 percent in the state of California.

The elderly are also the largest users of both acute care and long-term care facilities:

- The Average Length of Stay (ALOS) in a hospital for the elderly is 1 1/2 to 3 times longer than the ALOS for age groups below the age of 65 years.
- Discharges per 1000 increase dramatically with age, from 167 for all ages to 413 for those over 65, to 615 for those over 85 years of age.
- Those over 65 years of age visit physicians on average 6.3 times annually compared to 5.2 times for persons aged 17-44.
- Over 80 percent of the elderly report at least 1 chronic condition.

- The number of nursing home residents are projected increase from 1.5 million in 1980 to 5.2 million by the year 2040.

If the current incidence rate of chronic diseases for the elderly is applied to the above numbers, the results are staggering. Seven to eight million persons with Alzheimer's disease or related dementia's, and millions more disabled by osteoporosis, arthritis, Parkinson's disease, or incontinence.⁷

Nursing Homes and Long-Term Care

In 1988 there were 19,100 nursing homes that housed approximately 1.72 million residents.⁸ It is estimated that nursing home organizations will require between 320 and 600 new 100-bed facilities each year for the next 15 years in order to handle the demands of the elderly population for long-term care services.⁹ At the present time Federal and state governments, alternative Medi-Gap insurance plans, and the elderly themselves are sources of funding for this care. It is estimated that nursing home expenditures will grow from the current 0.8 percent of the gross national product to 1.2 percent by the year 2000 emphasizing the urgency for Federal and state governments to control costs.

Major areas of concern relative to long-term care are issues related to quality of service, cost containment,

availability, and access. This has created conflicts between the nation's elderly and health care organizations, nursing homes, and federal and state agencies responsible for paying for and providing for these services. The elderly want low cost health care while at the same time wanting the highest quality available. Federal and state governments responsible for managing costs related to Medicare, Medicaid/MediCal, and Social Security are concerned about the dramatic cost escalation of health care. Cost containment is also a concern for insurance companies and employers who would like to provide their policy holders and their employees with health care insurance at the lowest possible price.

As the cost of a year in a nursing home approaches \$40,000, long-term care is becoming the main cause of catastrophic health care expense for the elderly.¹⁰ In 1987, 43.9 percent of the long-term care provided was paid for by Medicaid, and the rest was paid for by private funds and private health insurance.¹¹ In 1988 total nursing home and home care for the elderly exceeded 40 billion dollars. Out of pocket expenditures accounted for 55 percent, and Medicaid accounted for 43 percent of all spending for nursing home care according to the Brookings Institute. Medicaid is the dominant source of public funding and accounts for nearly 80 percent of government spending for nursing home care and home care for the elderly. Medicare

generally pays for short term stays in Skilled Nursing Facilities (SNFs) and plays a negligible role in financing long-term care. Applicants whose income and net worth exceed a specified amount cannot become eligible for Medicaid coverage of nursing home care, even if their medical expenses exceed their incomes, unless they "spend down" to MediCal limits. In 1988 the maximum monthly income permitted for individual's eligible for Medicaid under this standard was \$1,944 plus \$12,000 in assets (this varies from state to state). In 1989 the "Medicaid Gap" was defined as those persons with monthly income above \$1,158 but below approximately \$2,300. Unlike those excluded on the basis of assets who may intentionally spend down to obtain eligibility, those excluded on the basis of income have no recourse if they can't find ways to decrease their income. Most elderly live on fixed incomes from retirement plans investments and social security.

Poverty and the Elderly

In a report entitled "Aging Agenda 1993-95: Legislative Platform," published by the California Association of Area Agencies on Aging and Long Term Care and the Triple A Council of California, it is stated that 12 percent of California's elderly population aged 65 or over subsist

below the poverty level on less than \$6,200 a year with 40 percent living on less than \$12,000 a year.

Holden and Smeeding¹² considered five specific sources of economic insecurity among the middle-income elderly as most crucial to their economic vulnerability that were inter-related but separable:

1. Medicare as the only acute health-insurance subsidy(or, in very rare cases, reliance on no health insurance at all).
2. Insufficient financial resources to cover two years(the median length of stay) in a long-term care facility.
3. Ineligibility for SSI even if all income other than Social Security should cease.
4. Housing costs as a percent of income above the accepted maximum.
5. Higher costs of living due to one or more sources of physical disability.

Although facing only one of these five conditions would not signal economic insecurity, combinations of these conditions (e.g., two or more) would almost surely create an insecure and unstable economic state for affected households.

Approximately one in three elderly face at least two of the five sources of insecurity.¹²

Community-Based Long-Term Care Services

Korbin, et al,¹³ collected data was analyzed in an attempt to estimate the costs of Community-based long-term care services for disabled elderly persons. This was done in order to be able to estimate total program costs under different program operations being considered by policy makers (Congress). Data were collected from the National Long-Term Care Channeling Demonstration Project, sponsored by the Department of Health and Human Services and Mathematica Policy Research.¹⁴ The findings indicated that both costs per community day and the likelihood that any costs would be incurred would increase noticeably if a program similar to the project were implemented nationally. This project began in early 1982, and 10 demonstration sites were set up to serve clients through early 1985. These sites employed two models of intervention: a basic model in which only case management was offered and a second model in which case management was enhanced with service payments. The evaluation of the data related to these projects highlighted the variability in expected program costs based on how eligibility criteria are established. The researchers also discovered that estimated program costs could be considerably lower if deductibles and co-payments were imposed.

Several features of the (1988) Catastrophic Health Care Act were designed to reduce the financial insecurity of the elderly but most provisions were repealed. Two of the provisions, Spousal Impoverishment and Low-income Protection via Medicaid payment or Medicare premium for the poor elderly were retained. The Spousal Impoverishment provision provides a more liberal exclusion of assets in the case of married couples where one needs medical or nursing-home long-term care. Only one spouse needs to spend down to the Medicaid limit. Still, the disabled elderly and their families find, often to their surprise, that neither private insurance nor Medicare covers the costs of long-term care to any significant extent.

Long-Term Care and Health Policy

A fundamental policy question is whether we can come up with a long-term care financing system that works better than the current system. The Brookings-ICF Long-Term Care Financing Model provides detailed projections of the number of disabled elderly to the year 2020 and four results of these projections are notable:¹⁵

1. The older population will grow rapidly, and the number of elderly will rise even faster, and more of the elderly will be disabled.

2. Older persons will be significantly better off financially by 2018.
3. Spending for long-term care will increase rapidly, especially for nursing homes.
4. The proportion of nursing home expenditures accounted for by Medicaid will not decline, nor will the proportion of nursing home patients dependent on Medicaid.

This last result is surprising due to the fact that if the well-being of the elderly is expected to improve substantially over the period, shouldn't they become less dependent on a program intended for the poor?¹⁴ The answer is no, primarily due to the fact costs of long-term care are going to increase at the same rate as the incomes of the elderly. The elderly's percentage of income available for health care will essentially remain constant. Goals for long-term care financing reform need to include and address the following issues and objectives:

1. To begin to treat long-term care as a normal risk of growing old.
2. Long-term care and its associated costs should not cause severe financial distress for the elderly.
3. To prevent elderly persons who have been

financially independent all of their lives from depending on welfare, with its indignities and stigma.

4. Reform of the long-term care financing system should also create a more balanced delivery system by expanding home care.
5. The long-term care financing system should also improve quality of care and the flexibility and efficiency of the delivery system.
6. These reforms should also limit the rise in long-term care expenditures and moderate the inflationary pressures on the long-term care industry.

Both the public and private sectors, along with individuals concerned, need to be involved in developing the solutions to these problems.

One alternative solution to the problem of long-term care is the Social/Health Maintenance Organization (S/HMO). A S/HMO combines the TEFRA Medicare Risk Contract with chronic and expanded care benefits in an attempt to keep the elderly at home and out of long-term care facilities. Literature review on the subject of S/HMOs suggest that they may have the potential to not only decrease the costs of care for the elderly, but to also keep them out of long-term care facilities longer, improve their quality of life, and

allow them to remain active productive members of society much longer while remaining at home with their families.

General Research Approach

This thesis will study and analyze and report on the potential for a Social Health Maintenance Organization (S/HMO), organized under the auspices of an established HMO, to provide acute, chronic, and expanded health care services for Riverside county's elderly population. This will be done, in part, by using needs based data provided by the 1993-1997 Area Plan of Riverside County's Office on Aging which defines the needs and demands related to health care for the seniors of Riverside County. This policy analysis will be evaluative in nature, assessing how well this type of program and service, based on previous descriptive and analytic research, has done in resolving the needs and demands of the elderly. The thesis hypothesis is:

Hypothesis

There are potential cost and service benefits associated with implementing and expanding the S/HMO model in Riverside County to provide acute, chronic, and expanded health care services for the county's elderly population.

Research Questions

Some research questions that will be addressed are:

- 1) What is the feasibility of planning and implementing a Social Health Maintenance Organization in Riverside County, for a large Health Maintenance Organization, to provide acute, chronic and expanded health care services for the county's elderly population.
- 2) Can an S/HMO, when compared to a standard HMO Medicare Risk Contract, decrease:
 - A) Hospital utilization?
 - B) Average Length of Stay (ALOS)?
- 3) Can an S/HMO Case Management process decrease the "cost to serve" the elderly member as measured by Per Member/Per Month (PM/PM) costs?
- 4) Can an S/HMO in Riverside County adequately "market" its services to enroll enough elderly members to control "adverse risk"?
- 5) Can an S/HMO in Riverside County adequately address the health care needs of the elderly?

CHAPTER II

LITERATURE REVIEW

Long-Term Care Services

Of the nation's thirty million persons over the age of 65, approximately 24 percent, or 7 million require some form of long-term care services. Long-term care services are those health, social, housing, transportation, and other supportive services needed by persons with physical, mental, or cognitive limitations sufficient to compromise independent living.¹⁶ Long-term services include: housing, social activities, food preparation/delivery/feeding, in-home care, transportation, and medical care services.....¹⁷ These services also include the need for some household tasks such as shopping, and/or personal care needs such as bathing, and dressing.

Of the approximately 24 percent of the elderly requiring some kind of assistance, only 30 percent, or 2 million, have limited dependencies while 20 percent, or 1.4 million, are completely dependent, requiring assistance in all of their daily activities.¹⁸ The need for long-term care services increases with age, only 12.6 percent of those aged 65-69 years require some long-term care services, for those aged 75-79 years the percentage increases to 23.4 percent,

and for those 85 years and above, 55.3 percent require one or more long-term care services.¹⁹

Long-term care is concerned not with cures of disease, but with consequences of disease and disability. It focuses on providing support for those who are seriously disabled and unable to perform activities of daily living (ADLs) such as getting in and out of bed or chair, bathing, dressing, using the toilet, walking, or eating, as well as the instrumental ADLs (IADLs), such as preparing meals, grocery shopping, doing laundry, or performing housekeeping chores.²⁰ Long-term care deals with the infinite combination of physical strength and abilities, mental stability, mobility, tolerance for pain, cognition, sensory acuity, and emotional strength, as well as the safety and security of the care setting, and the family's willingness to help. In summary, long-term care refers broadly to the medical, residential, and social services that are provided to chronically disabled persons over an extended period of time, either in their own home or in a separate facility. The major sources of long-term care for the dependent elderly are: with a spouse (32.7 percent), with others (20.7 percent), in nursing homes (19.4 percent), and in board and care homes (3.7 percent).²¹

Long-Term Care Alternatives

The spectrum of long-term care services available for the nation's elderly include:²²

- 40,000 Board and Care Homes that care for 550,000 elderly (provide support for ADLs)
- Congregate Housing Arrangements (similar to above, but for those with higher incomes) These may be publicly or privately funded and provide primarily non-medical services to the frail elderly such as meals and social services, and other supportive services that allow the person to remain independent.
- Life Care Communities - the person lives independently and as they require additional services they receive assisted living services as well as nursing home care when needed. Life Care Communities have several advantages and disadvantages. They offer protection against depletion of a person's assets and access to good quality nursing facilities for its members, but, many aged do not want to leave their communities and move into a new community. Because of the high initial investment and significant fees, such communities are applicable to only a small percent of the aged.

- Life Care at Home - Whereby the elderly can purchase varying levels of services to enable them to remain in their home as long as possible.
- Social HMOs (S/HMOs) are Health Maintenance Organizations that are financed by an aged person's Medicare payments (Part A and B) plus an additional amount to provide long-term care benefits, primarily in the home. S/HMOs coordinate acute and long-term care needs of their elderly members. Very few HMOs offer long-term care services under TEFRA Medicare Risk Contracts to their aged subscribers and when they do, the long-term care benefits are limited to episodes of acute care and do not guarantee a subscriber long-term care should they need it.
- Home Equity Conversion is another method that has been proposed to allow the elderly to pay for long-term care services. It is simply "reverse mortgaging" in which the owner essentially sells their house to the bank or lending institution in return for a monthly payment for a predetermined number of years. The disadvantages are that it is psychologically difficult for the aged to mortgage their homes, the person may outlive the mortgage payments, or the payments may be insufficient for

the person's long-term care needs, and since Medicaid or MediCal treats the home as a protected asset for the spouse the family be required to deplete the asset. Home equity is more applicable for meeting the elderly's daily living needs rather than being used for economic efficiency.

Economic Factors Affecting the Elderly

Most people believe that the elderly are protected from the high cost of health care by the Medicare program. Unfortunately, an examination of elderly out-of-pocket expenses for health services indicates this is far from true. America's elderly families had out-of-pocket expenses of over \$67 billion for health care in 1991.²³ The alternatives discussed in this thesis not only must provide services that meet the needs of the elderly community but also do it at a reasonable cost in line with budget expectations of the elderly and the organization providing the necessary health services. Many Americans live in fear that a serious illness or the long-term care needs of an elderly family member will mean financial ruin for themselves and their families. Many of our elderly population, especially those living on a fixed income, need some assurance that they won't become financially destitute if they require long-term care. In 1988 the elderly spent

12.5 percent of their income after taxes on health care compared with 9 percent in 1960 prior to Medicare.²⁴ Real out-of-pocket spending per elderly household has grown by 22.5 percent since 1984, and more than doubled since 1961. Spending for Medicare premiums per elderly family increased by 50 percent in real dollars since 1972.

Long-Term Care Expenditures

Some statistics relative to Long-term care expenditures are:

- Total long-term care costs are expected to exceed \$50 billion
- Approximately \$43 billion will be spent on nursing home care and \$8 billion on home care
- Over their lifetimes 15 percent of the elderly will incur long-term care costs greater than \$80,000 and most expenses incurred will be by those 80 years old or older
- 15 percent of nursing home entrants begin their stays as private-pay patients and spend down to Medicaid or MediCal
- 35 percent of nursing home entrants receive MediCal benefits within the first month of residence

The need to find alternative long-term care financing arrangements will be acute. Annual baseline projections of the number of elderly requiring nursing-home care imply that

annual expenditures for nursing-home care will increase from about \$44 billion in 1990 to \$98 billion by 2020 and \$187 billion by 2030.²⁵ The increase in the number of people aged 65 or older along with the continuing shortage of nursing home care facilities, which already is reflected by both waiting lists and 95 percent occupancy rates, will continue to contribute to the spiraling costs of long-term care.²⁶

Alleviating Concerns of the Elderly

The elderly hope to alleviate several concerns related to long-term care by participating in long-term care programs.²⁷

1. Most aged would prefer to stay out of a nursing home and be treated in their own home as long as possible. Long-term care benefits should be able to provide the aged with coverage for services in their home.
2. If a person has to enter a nursing home it should be a good quality facility. Given the shortage of nursing homes as a result of regulations limiting their supply, access to a good quality nursing home is the major reason why the elderly join life-care Communities.
3. The aged that have assets desire to protect their estates, either for spouses or children.¹⁸

This thesis will attempt to prove that a S/HMO can assist the elderly in alleviating their concerns by addressing the above.

Area Office on Aging: Goals

The Riverside County Office on Aging, as part of its Changing Aging Communities plan, developed eight goals for its' program in support of self determination and independence for the elderly of the county. One of these goals, Goal #4, is to assist the health care community in addressing the need for Health Care System Reform with special emphasis on the development of adult day health care service in the county, and the inclusion of mental health and preventive health service, long-term care, and chronic care in a comprehensive health insurance package.

The Office on Aging's Needs Assessment and its associated Areas of Service will be used for guidelines for the development and analysis of the Social HMO concept for Riverside County. This thesis will attempt to identify which of these needs and areas of service can be addressed by the S/HMO concept and which ones fall out of the realm of S/HMO responsibilities and capabilities.

Social Health Maintenance Organizations (S/HMOs)

Background

S/HMOs provide acute and long-term care services for the elderly under one cost effective insurance and delivery system. S/HMOs plug the gaps in Medicare and most private insurance, including HMOs, by providing extra benefits such as prescription drugs and as much as \$1,000 per month in community-based long-term care benefits. These benefits include personal care, skilled nursing, therapy services, adult day health care and short-term nursing care.²⁸ The S/HMO's long-term care benefit structure provides longer and more intensive post-acute care, ongoing monitoring and service for the medically complex and unstable, long-term in-home and community-based support for ADLs, dependencies, and other associated social and medical needs. It appears to give beneficiaries what they want - the chance to stay at home with maximum independence for as long as possible.²⁹

S/HMOs versus HMOs

S/HMOs are different in several ways from an HMO or Competitive Medical Plan (CMP) that participates as a Medicare Risk contractor under the 1982 Tax Equity and Financial Responsibility Act (TEFRA).³⁰

- 1) TEFRA HMOs and CMPs generally do not provide

Medicare enrollees benefits beyond those acquired by Medicare while S/HMOs do.

- 2) HMOs and CMPs are not permitted to screen the health status of enrollees - By contrast S/HMOs are permitted to conduct functional health screening of their applicants, and at their discretion, can elect to put functionally impaired persons on waiting lists for the health plan.
- 3) TEFRA HMOs and CMPs cannot have more than 50 percent of members be Medicare/Medical eligible and cannot have fewer than 5000 members if located in an urban area.

Initial Implementation

Federal interest in the S/HMO concept grew out of three issues affecting delivery of health and long-term care services:

- 1) The increased availability of risk-based, managed-care Medicare alternatives.
- 2) The absence of appropriate insurance mechanisms for long-term care.
- 3) The under-development of home and community-based chronic care services, and the fragmented arrangement for managing the care of functionally

impaired older persons across the full range of acute and long-term services.

Four S/HMO demonstration projects were established in 1985 by Brandeis University and funded by the Health Care Financing Administration (HCFA).³¹ The S/HMOs were established by two types of sponsors: two HMOs and two Long-Term Care Organizations. Kaiser Permanente Northwest, an HMO in Portland, Oregon developed Medicare Plus II. A partnership between a mature HMO and an experienced direct long-term care service provider - Group Health Inc. and Ebenezer Society in Minneapolis-St. Paul, Minnesota, developed Seniors Plus. The Metropolitan Jewish Geriatric Center Inc., a direct service provider in Brooklyn, New York, developed Elderplan. Senior Health Action Network (SCAN), a long-term care service broker in partnership with a large medical center in Long Beach, California became the sponsor of Senior Health Action Network (SCAN).

S/HMO Model Overview

The S/HMO model tested by the HCFA demonstration projects included four unique organizational and financing features:³²

- 1) A single organizational structure was established to provide a full range of acute and chronic-care

services to Medicare beneficiaries who enroll on a voluntary basis and pay a monthly premium for services. Benefits covered included all basic benefits covered under Medicare, Chronic care services for custodial nursing home, home care, homemaker, respite care, and other services are provided for those who meet a pre-established level of disability. Chronic care benefits are limited, depending on the organization, from \$6,500 for Elderplan to \$12,000 per year for KP Medicare Plus II. Expanded benefits (different from Expanded Care Benefits) for all members include outpatient prescription drugs, hearing aides, eyeglasses, and other such services.

- 2) A coordinated case-management system was implemented. Case managers approve service authorizations for chronic care services within the specified benefit limitations for those members who meet specified disability criteria (usually two limitations in ADLs). The case management system is designed to ensure access to an appropriate level or type of service, while ensuring appropriate cost controls.

- 3) Enrollment of a cross section of the elderly population, including both the functionally impaired and the well elderly.
- 4) Financing that is accomplished through prepaid capitation of pooled funds from Medicare, Medicaid, and member premiums. The initial financial risks would be shared by both the S/HMOs and HCFA.

Chronic Care Benefits

All the S/HMOs established small, fixed chronic-care benefit packages to limit their overall financial risk. Comprehensive assessments were conducted for each individual in the person's own home by the case managers to determine the need for services. Periodic assessments were completed by the case managers every six months or on an as-needed basis. The chronic-care benefits were authorized and monitored by case managers at each site.³³ Chronic care services were allocated to individual members who met specific criteria. Most had to meet Nursing Home Certification Criteria of two or more limitations of ADLs. Each of the S/HMOs also had contractual arrangements with long-term care providers and these arrangements generally appeared to help control costs and assured member access to chronic-care services.

At all HMO S/HMO sites, members are assessed for qualifications for chronic care services using information gathered in a face-to-face visit by a Resource Coordinator (the coordinator uses the Research Consortiums Comprehensive Assessment Form-CAF), Appendix E, and another form for determining nursing home certification specific to the state of the site.³⁴ One of the major fears of potential insurers for long-term care - from both the public and private sectors - has been that community benefits could not be controlled. The S/HMOs have been successful in controlling utilization of long-term care services by tying patient eligibility to the need for nursing home care.³⁵

Expanded Care Benefits

To receive services covered by the expanded care benefit (community-based long-term care services), a member needs to be judged as being severely impaired and in actual need of help from another person on a daily basis in at least one of the following areas:³⁶

- 1) Mobility
- 2) Feeding
- 3) Danger to self or others
- 4) Cognitive functioning (need for supervision and protection)

- 5) Health conditions (regular nursing care/severe impairment)
- 6) Medication management
- 7) Toileting
- 8) Bowel and bladder control

Each site had to offer all Medicare-covered services, a range of ancillary medical services, plus a full array of expanded community care and nursing home services for chronic conditions excluded by Medicare, HMOs, and Medicare Supplementary Insurance. Expanded care services include personal care, homemaker service, day care, respite care, transportation, and institutional care. These benefits are controlled through a variety of benefit caps, benefit status, and member co-pays.³⁷ Expanded Care benefits are controlled by an independent case management unit staffed by a mix of nurses and social workers. They assess members and authorize care plans that can include those mentioned previously plus electronic monitoring, and short-term nursing home care.³⁸

S/HMO and Private Long-Term Insurance

Greenlick³⁹ makes several comments relative to this comparison: First, the S/HMO puts the bulk of its benefit dollars into community care, while conventional long-term care insurance plans put most of their coverage into nursing

home care. Although the S/HMO has a gap in coverage for those who are appropriately placed in custodial nursing homes, the S/HMO gives beneficiaries and families the incentive and the means to achieve the goal that most have, to stay at home as long as possible. Second, the S/HMO is relatively affordable. Third, the S/HMO offers first-dollar coverage as compared to the significant deductibles (30 to 100 days is common) of many nursing home plans, and no prior hospitalization or nursing home placement is required. This is another financial aid in maintaining community residence. Fourth, and perhaps the most important, the S/HMO's expanded benefits are closely managed, and services are integrated with acute care. In conventional long-term insurance, however, there is little if any, case management let alone coordination with the beneficiary's medical care system.

Caps on Services

Two basic models were used in placing caps on certain services. Elderplan and SCAN have integrated their caps for community and nursing home services. A set annual dollar amount is available to the member in either setting or any combination of the two (community/nursing home service caps). The annual limits in 1987 were \$6,500 at Elderplan and \$7,500 at SCAN. In contrast, Kaiser Permanente's Medicare Plus II and Seniors Plus have separated their community and

nursing home caps and have defined each differently. For all settings and services combined there was an overall limit in 1987 of \$6,500 at Seniors Plus and \$12,000 at Medicare Plus II. All four sites charge co-pays, which vary in level and structure. The KP Medicare Plus II \$1000 per month of community-based care does not cover 24-hour nursing care at home for more than a few days, but it does augment care provided by informal care givers in the home. Community-based services are often used to support the members primary caregiver and provide needed respite. In this way, an important goal of supporting the informal care system rather than replacing it with formal services is achieved. The 10 percent co-pay also encourages informal care, augmented with chronic care services as needed.

Summary of Literature Review

The Literature Review attempts to bring into focus the needs of the elderly and the limitations of present long-term care policies and services. The county's elderly population over the age of 65 is growing rapidly. Health care services available to them are either limited, relatively inaccessible, or too costly for most of the elderly who for the most part are on fixed incomes.

The Social Health Maintenance Organization Demonstration Project Sites were more expensive to start up

than expected, especially the two S/HMOs associated with LTC organizations. The S/HMOs were generally not able to break even until the fourth year of operation. Newcomer makes the following observations:⁴⁰

- 1) From an organizational and management perspective, developing a S/HMO in the context of a mature HMO is less expensive and administratively less complicated than beginning the program on the base of a long-term care provider.
- 2) Long-term care organizations must develop an acute care service infrastructure for their member recruitment and a fundamental service system for the HMO component of the S/HMO model.
- 3) Long-term care organizations and state Medicaid programs interested in developing S/HMO type integrated health plans should understand the considerable staff, Financial resources and prepaid acute health care managerial expertise that is necessary for successful S/HMO start-up and that the creation of new health plans will need substantial external assistance to share the financial risk during developmental periods.
- 4) The key organizing questions appear to be how to integrate the S/HMO concept with existing acute care delivery systems and how to simultaneously

market more than one Medicare prepaid health plan product.

- 5) HMOs and CMPs could have difficulty in simultaneously marketing both S/HMO benefit packages and high option TEFRA packages.
- 6) Chronic care benefit expansion though requiring concerted effort, is achievable.

The next chapter will analyze two alternatives related to health care for the elderly. The standard TEFRA Medicare Risk Contract provided by a local HMO and the S/HMO concept and its potential application to Riverside County.

CHAPTER III

ANALYSIS

Alternatives

There are a multitude of "Senior Programs" being marketed by many managed care organizations this thesis will focus on two alternatives. These two alternatives utilize an integrated case management function that ties acute, chronic care, and expanded services together under the same organizational umbrella. The first alternative is a standard "HMO Medicare Risk Contract." The second is a "Social HMO" function which combines the standard TEFRA Medicare Risk contract along with chronic care and expanded services and benefits. Both will be analyzed as to structure, services, and benefits. Kaiser Permanente's Medicare Risk Contract, Health Pledge, and Kaiser Permanente's Portland Oregon S/HMO, Medicare Plus II will be used as examples and comparisons in this analysis.

S/HMO Objectives

An S/HMO, while assisting the elderly to remain out of a long-term care facility as long as possible, is also able to provide adequate health care for the elderly at a reasonable cost given that it can control adverse risk and acute care utilization by its elderly member population. The

S/HMO should be able to provide acute and long-term care services for the elderly under one cost effective insurance and delivery system. The S/HMO's objective is to expand prepaid coverage of community and nursing home care in a controlled manner and to link these expanded LTC services with a complete acute care system.⁴¹ The S/HMO's long-term care benefit structure objective provides:

- Longer and more intensive post-acute care.
- Ongoing monitoring and service for the medically complex and unstable.
- Long-term in-home and community-based support for ADLs (Activities of Daily Living).
- Short-term nursing home stays for convalescence, respite, and other purposes.

These benefits appear to give beneficiaries what they want: the chance to stay at home with maximum independence for as long as possible.

Relevant Population

Riverside County demographics gathered from Census Bureau statistics demonstrate the following information relative to the county's elderly population.

- Over 17 percent (201,722) of the total population (1,160,927) in Riverside County is age 60+, compared to 14 percent in the state of California.

- Over half of the total population age 60+ live east of the Riverside/Moreno Valley area.
- The population aged 85+ in Riverside County grew 77 percent in the last decade compared to 37 percent in the state of California.
- Riverside, Hemet/San Jacinto, Perris, Cathedral City/Palm Desert, and Palm Springs have the highest number of seniors in the county.
- Hemet/San Jacinto, Beaumont, Banning and Palm Springs have the highest percentage of seniors over the age of 85.

Table 1(following page) is data extracted from the 1990 U.S. Census Community Service Area(CSA) census data for Riverside County reflecting the county's numbers of elderly aged 60+.

Universe of Need and Demand Generation

As mandated by the Older Americans Act, the Office on Aging developed a strategic plan for Riverside County. The plan analyzed demographic data, evaluated needs assessment results, identified those most in social and economic need, and sets policy direction and priorities. In 1992 it conducted an elderly needs assessment for Riverside County.

TABLE 1

COMMUNITY SERVICE AREA CENSUS DATA - AGE 65+

<u>AREA</u>	<u>NUMBER</u>	<u>PERCENT OF</u> <u>POPULATION</u>
PALO VERDE VALLEY	2,414	13 percent
COCHELLA VALLEY		
West Valley Area	24,459	27 percent
Mid Valley Area	20,093	33 percent
East valley Area	8,536	10 percent
MID COUNTY		
Pass Area	12,524	26 percent
Hemet/S. Jacinto	43,552	39 percent
METROPOLITAN		
Riverside	23,522	12 percent
Rubidoux	8,364	11 percent
Norco	2,879	6 percent
Corona	5,736	9 percent
Moreno V./Perris	20,968	9 percent
SOUTHERN		
Sun City/L. Elsinore	18,000	25 percent
Temecula/Murrieta	10,675	14 percent
TOTAL	201,722	17 percent

Universe of Need (Cont)

This needs assessment was done by:

- Convening the following:
 - Ten senior focus group sessions
 - Nine community planning forums
 - Senior center directors
- Conducting Surveys
 - A minority needs assessment survey was completed among the Hispanic community throughout the county.
 - A survey was completed of over 40 entities in the county that offer Information and Referral Services to the elderly.
- Participating in conference planning sessions
- Participating in other needs assessment and planning activities
- Interviewing key informants
- Reviewing national trends
- Identifying the location of target populations
- Completing a Minority Needs Assessment
- Holding Public Hearings

This Needs Survey identified thirteen needs which were prioritized into three groups:

Priority 1 Group:

- Access to services with information and assistance linked to follow-up case management.
- Transportation for medical and personal trips
- In-home health and in-home support services
- Day health care and respite care
- Service Coordination and advocacy

Priority 2 Group:

- Health insurance and health care costs
- Affordable and safe housing
- In-home meals and vouchers for food
- Mental health support and social isolation

Priority 3 Group:

- Legal/crime issues
- Employment/retirement/financial issues
- Quality nursing home/hospital care
- Recreational/social opportunities

These identified needs were then grouped into the following areas of service related to health care:

A. Access to Services

- Transportation

Travel vouchers or vehicles to transport the elderly to medical or other appointments..

B. Home-based Services

- Homemaker
Assistance with shopping, meal preparation, light housekeeping, and laundry..
- Home delivered meals
Hot meals delivered to the home of homebound elderly who cannot prepare their own meals.
- Home health care
Skilled care and supportive services

C. Community-based services

- Congregate Meal Program
Provides elderly with nutritional hot meals daily.

D. Health-care Programs

- Respite Care
Short-term relief to families caring for frail elderly.
- Adult Day Care
A lower cost alternative to institutionalization for adults who cannot stay alone during the day.
- Hospice Care

Provides special care to terminally ill patients and their families in either home-based or through in-patient facilities.

- Long-term Care Ombudsman Programs
Assistance with nursing home regulations, abuse of residents, and access restrictions.

E. Financial Assistance

- Medicare/Medicaid

The Riverside County Office on Aging Needs Assessment also identified the elderly's needs relative to adequate health care. In-line with services provided by a potential S/HMO the elderly want and need:

1. Expanded in home health care coverage and adequate insurance coverage for these services.
2. Quality standards and information on reputable providers of in-home health care for the consumer.
3. Effective discharge planning to set up home health care in coordination with other support services.
4. Quality hospitals and nursing homes staffed with dedicated caregivers and enhanced through local community involvement and support.
5. Treatment for substance abuse and depression among seniors that accommodates their special needs.
6. Integration of mental health care with other parts of the service delivery system.

7. Screening programs to identify the at-risk individuals and make referrals to care through increased community and volunteer participation.
8. Expansion of preventive health services/health education that deals with life style behaviors and management of chronic conditions to improve the health status of seniors.

Social and Support Status

Statistics provided by the California Associations of Area Agencies on Aging and Long-term Care and the Triple-A Council of California⁴² indicate that the demand and desirability for long-term care in the home, in the community, and in institutional settings will continue to grow. Nearly 25 percent of the 65+ population currently need assistance with the basic activities of daily living. The following trends and projections depict the age, social, health and economic profile of 4.2 million older Californians.

- 8 percent are homebound
- 21 percent have one or more chronic disabilities
- 15 percent cannot perform one or more basic ADLs.
- 30 percent live alone
- 15 percent live with children, relatives or friends

TABLE 2

COMPARISON OF BENEFITS

SERVICE	S/HMO BENEFIT	HMO BENEFIT
Premium	\$144.00 (Medicare Plus II)	\$79.00 (Medicare Plus I)
Acute Hospital	Unlimited number of days at prescribed hospital, Medicare Benefits covered in full	Same as S/HMO
Psychiatric Hospital	190 days lifetime benefit, no co-pays, no charges.	190 days lifetime benefit. First 60 days no charge, co-pay for each day there after until 190 day limit reached
Skilled Nursing Facility	Medicare coverage plus up to 14 days of care in support of on-going home care. (20 percent co-pay)	Generally covered in full, 100 days per calendar year or spell of illness, whichever is greater
Physician's services	\$5 co-pay per visit to doctor, includes vision, hearing and physical exams	\$5 co-pay per visit to doctor, includes vision, hearing and physical exams
Mental Health OP visits	Kaiser: 6 visits per year	Coverage varies by plan
Blood	Medicare Benefits covered in full	Same as S/HMO
Medical Equipment and Supplies	Medicare Benefits covered in full	Same as S/HMO
Lab and X-ray	Medicare Benefits covered in full	Same as S/HMO
Dentistry	Medicare Benefits covered in full	Same as S/HMO
OP Physical Therapy and Speech Pathology	Medicare Benefits covered in full with co-pay of \$5	Medicare limits only

(Table 2 cont'd.)

SERVICE	S/HMO BENEFITS	HMO BENEFITS
Pharmacy	Prescription drugs covered. \$5 co-pay	Medicare coverage only
Optometry	Covered in full, \$5 co-pay	Medicare limits only
Audiometry	Covered in full, \$5 co-pay	Medicare limits only
Foot care	Medically necessary podiatry. \$5 co-pay	Medicare limits only
Eyeglasses	Covers 1 pair each 24 month period	Medicare limits only
Hearing aids	Covers one hearing aid every three years. 50 percent of non-member charges	Not covered
Dentures	Not covered	Not covered
Home-health services	Medicare home-health covered in full. Coverage expanded beyond skilled care and homebound criteria when approved for long-term care plan.	Medicare limits only
Hospice	Covered in full	Covered in full when approved
Expanded Care	Care in your home (Covers up to 80 percent or \$800 per month) Care in nursing facility (80 percent up to \$800 of the cost up to 14 days per period of confinement)	Not covered

(Table 2 cont'd.)

SERVICE	S/HMO BENEFITS	HMO BENEFITS
In-home support services	Covered with limits (up-to \$12,000 annually), 20 percent deductible, Kaiser pays 80 percent up to \$9,600, member pays remaining, member pays 100 percent thereafter) - Help with personal care - Respite care - Homemaker services - Adult day health care - Additional nursing care for help with medications - Referrals for non-covered services	Not covered
Nursing home custodial	Up to 14 days of care in a nursing home (SNF or ICF) in support of ongoing home care per calendar year. (co-pay and limits same as In-home support services)	Not covered

TABLE 3

MEDICARE BENEFITS
HOSPITAL INSURANCE (PART A) COVERED SERVICES

MEDICARE		KAISER
Benefits & Services	Costs & Conditions	
Premium or subscription Charge	No charge, Created under Social Security Program	No monthly premium when enrolled in both Part A and Part B of Medicare (Group Dependent)
Deduction on entry to hospital	You pay \$676 deductible for first 60 days per benefit period. Days 61 through 90 cost \$169 per day. For reserve days used (60 per lifetime) you pay \$338 per day.	No co-pay, no deductible, covered in full
Skilled Nursing Care in a facility approved by Medicare	First 20 days free. You pay \$84.50 each day from 21st through 100th day per benefit period	Covered up to 100 days per calendar year or per spell of illness, whichever is greater

MEDICAL INSURANCE (PART B) COVERED SERVICES

MEDICARE		KAISER
Benefits & Services	Costs & Conditions	
Premium or subscription charge	You pay \$36.60 per month plus a \$100 annual deductible	No premium charge
Physician & surgeon services, diagnostic tests, physical & x-rays.	Medicare pays 80 percent of allowed charges, you pay 20 percent	\$5 co-payment per visit to doctor, covered in full
Out-patient prescription drugs	Medicare pays 100 percent of <u>in</u> -patient drugs	Not covered

TABLE 3 (Cont)

OTHER

MEDICARE

KAISER

Benefits & Services Costs & Conditions

Pre-existing health conditions	No restrictions	Cannot have end-stage renal disease or be enrolled in a Medicare Hospice Program
Renewability of contract	Cannot be canceled	You must continue to pay your Part B premiums and continue your group's (if applicable) and Kaiser Permanente's eligibility requirements. Kaiser must also continue to receive any monthly dues payment for you either from your group or from you directly
Travel restrictions	Covered in U.S. & possessions. May use in Canada & Mexico under specific conditions	Covered world-wide for urgent and emergency care
Geographical area covered	U.S. & possessions (includes Puerto Rico, U.S. Virgin Islands, Guam, American Samoa & Northern Mariana Islands)	Covers portions of Kern, Tulare, Los Angeles, Orange, Riverside, San Bernardino, San Diego and Ventura Counties.

Alternatives (Benefits)

Outlined in Table 2, Comparisons of Benefits, are the differences between the two alternative benefits packages, a Social HMO and an HMO with a TEFRA Medicare Risk Contract. Table 3 describes the standard Medicare Benefit and the HMO TEFRA Medicare Risk Contract.

S/HMO Differences

As demonstrated in Table 2, Kaiser Permanente's Social HMO, Medicare Plus II provides all benefits of a TEFRA Medicare HMO risk contract with the following differences:⁴³

Benefit Package

Premium or subscription charge: A nominal monthly fee

Risk-contract HMOs do not provide Medicare enrollees community-based chronic care services. The essence of the S/HMO concept is to provide chronic care benefits to functionally-impaired beneficiaries in a prepaid health care environment. In contrast to S/HMOs, TEFRA HMOs make no attempt to integrate Medicare and Medicaid services into a single benefit package.

TEFRA HMOs are not permitted to screen the health status of applicants prior to enrollment. The S/HMO model tested in the demonstration uses a form of functional status screening, referred to as "queuing." S/HMOs are allowed to screen applicants to assure that they enroll a

representative community sample of functionally impaired persons. this queuing mechanism, in theory, protects both the S/HMO and the government from adverse risk.

Enrollment Limits

TEFRA HMOs cannot have more than 50 percent of their members be Medicare and/or Medicaid eligible and cannot have less than 5,000 members if located in an urban area.

Rate Setting

TEFRA HMOs receive a monthly payment of 95 percent of the AAPCC for Medicare enrollee from HCFA. The S/HMOs, at least in the demonstration, receive 100 percent of a modified Average Annual Per Capita Cost of Fee for Service Provider(AAPCC) for each enrollee.

Risk Sharing

TEFRA HMOs are at full financial risk for all costs incurred. At the present time HCFA and State Medicaid programs agreed to share financial risk with the S/HMO sites, in essence, underwriting the venture.

S/HMO Model

The model for an S/HMO managing a Medicare Risk Contract with expanded services is essentially no different from a standard HMO, with the exception of its Chronic Care Services Management, HCFA Medicare regulations previously

discussed, and HCFA capitation rates. Evidence to date indicates that from an organizing and management perspective, developing the S/HMO concept in association with a mature HMO is less expensive and less complicated than having long-term care providers develop an acute care services infrastructure. For mature HMOs, the key organizing question is how to integrate the S/HMO concept with existing Medicare product lines, both in terms of marketing strategies and service delivery.⁴⁴ In an HMO the S/HMO services are treated as a new product line. In so doing, an HMO can make efficient use of its administrative resources, including hospital and SNF Utilization Review and Discharge Planning Staff, without repeating these functions.

Medicare Plus II

An organizational chart of the Kaiser Permanente Medicare Plus II S/HMO, Appendix B, will be used in the following discussion and outline of an S/HMO.

Acute Health Care Services

For acute health care services, S/HMO enrollees receive services in the same manner as any other HMO enrollee. Only those chronic care services unique to the S/HMO concept were the fiscal responsibility of the S/HMO administrative structure as evidenced by the Medicare Plus II block on the far right of the Organizational Chart in Appendix 2.

Chronic Health Care Services

The Chronic Care Services of the S/HMO are capitated, and the support services for its function are Administration, Case Management, SNF/ICF Coordination, Home Health Homemaker, and other Long-Term Care services. All other services were fully integrated into the regular Kaiser HMO delivery system. The Medicare Plus II S/HMO had little difficulty negotiating contractual arrangements with providers of institutional or community-based long-term care services in support of the expanded care benefit package. This supports the hypothesis that an established HMO could also easily absorb S/HMO enrollees with few dramatic impacts on policies and procedures for providing services or the have difficulty negotiating special financial arrangements with providers external to the organization.⁴⁵ One problem area for an HMO establishing S/HMO services may be marketing which will be discussed in the Conclusion Chapter. Criteria for eligibility into the S/HMO program was discussed in detail earlier in this thesis in Chapter II.

Case Management

The S/HMO Case Managers coordinate with primary care physicians at various medical offices. Generally the Case Managers encourages family members or clients to take responsibility for medical care and interaction with the

physicians. Primary Case Management roles at Medicare Plus II include:⁴⁶

Screening and Assessment:

Medicare Plus II uses the case manager as the member's point of contact for entry into the long-term care system.

Care Planning and Service Arrangements:

After eligibility for services is determined, a case manager develops the plan of care. The plan of care is composed of the following components:

- 1) Development of problem-oriented care plans with specific objectives, scope, and duration of services.
- 2) Exploring care options with the client and family.
- 3) Explaining service costs and co-payments.
- 4) Reinforcing and supporting family care giving
- 5) Developing the most cost-effective mix of services within the constraints of the benefit package.

Monitoring Chronic Care Services and Resource Allocation:

When clients initially receive community-based services and/or home care, case managers closely monitor their needs via frequent telephone calls with the client and family. Case managers also participated in weekly case conferences which allow them to review their care plans. These

conferences serve as a quality assurance and utilization review function for the chronic care functions monitored by the case managers. Once the new services are in place and working well monitoring becomes less frequent. It is important to emphasize that the case managers have a stringent budget available to them. In 1989 Medicare Plus II had an annual chronic care benefit of \$12,000 annually or approximately \$233 a week that was available for case managers to draw on when developing a care plan. For members with short-term chronic care service needs, benefit limits usually posed no problem. For a highly impaired member requiring services on an ongoing basis, these services have to be carefully allocated. Medicare Plus II case managers utilize a computerized authorization system to enter and track data on:

- The provider/vendor/company from which services were purchased.
- The type of service provided.
- Beginning and end of the service period
- Frequency of the service and the number of service units used.
- The unit costs for each service

A computerized system is then used by the case manager to calculate total costs authorized for both the service period and to track year-to-date costs against HCFA capitation.⁴⁷

Utilization Review(Hospital and Nursing Home)

Acute Hospital Services:

For acute hospital services Kaiser Primary care physicians and medical specialists admit Medicare Plus II S/HMO clients to a Kaiser Hospital. Kaiser HMO staff perform all utilization review and discharge planning functions for hospitalized S/HMO clients.

Chronic Care Services:

Clients potentially eligible for chronic care services are referred to the Medicare Plus II S/HMO case managers for an assessment and determination of eligibility for expanded benefits. The S/HMO chronic care services package integrates institutional nursing home care and non-institutional, community based services. Decisions on how to appropriately allocate these services are controlled by the S/HMO case managers.

Nursing Home Services:

For Nursing Home Services the Medicare Plus II S/HMO use outside SNFs and ICFs for nursing home care. Although the Medicare Plus II S/HMO case managers made arrangements for the nursing home placements, responsibility for monitoring the quality of care and discharge planning rested with the Kaiser HMO SNF Coordinator. The Kaiser HMO SNF

Coordinator in turn coordinated with the S/HMO case manager when the member was eligible for chronic care benefits.

Community-Based and In-Home Services:

At Medicare Plus II the majority of in-home services for S/HMO members were initially provided by Kaiser's own certified home-health agency--which also operates its own hospice program and chronic care program. This support has now dropped to 10 percent or less. The majority of in-home services are now contracted out. If a S/HMO member qualifies for home care under traditional Medicare regulations, the S/HMO case managers are not involved but if services are covered under the chronic care benefit, the person is transferred to a S/HMO case manager for follow-up. The Medicare Plus II case managers are responsible for finding an available vendor, authorizing the level of services, and terminating the services when appropriate if the Kaiser Home Health Agency could not provide the service.

Discharge Planning:

At Medicare Plus II hospitalized members are assessed for nursing home certification(NHC) by one of the case managers. If the member qualifies, a care plan is jointly developed by both the discharge planner and the case manager. If the member qualifies for nursing home care or home care at discharge under Medicare criteria, the S/HMO

chronic care benefit is not activated, and the discharge planner assumes responsibility for the case. If the patient appears to be eligible for chronic care benefits, discharge planning is coordinated with the S/HMO case managers.⁴⁸

Record Keeping and Developing a Management Information System:

At Medicare Plus II a case manager is assigned the responsibility of over-seeing the Management Information System(MIS) which is primarily composed of personal computers utilizing the Paradox database. An MIS representative along with one of the case managers, is responsible for insuring that the computer system and applications are by the other case managers. The MIS keeps data on the following information related to S/HMO members:⁴⁹

- Health Status Form(HSF)
- Comprehensive Assessment Form(CAF)
- Nursing Home Certification Form(NHC)
- Care Plan
- Service Authorization Form
- Change in Care Plans or Service Authorization
- Physician Referral Form
- Progress Notes

Other Membership Services:

The case managers are intermittently involved in member-related activities such as making presentations, handling special inquiries about the chronic care benefit, and following up minor complaints and grievances. Table 4 shows the Case Management Department Staffing patterns for 1986 and 1993.

TABLE 4

MEDICARE PLUS II CASE MANAGEMENT STAFFING

STAFFING	1986	1993
Supervisors	1.55 FTEs	3.0 FTEs
Project Asst.	0.0 FTEs	2.0 FTEs
Case Managers	4.50 FTEs	7.0 FTEs
Util. Rev./ Disch. Planners	0.0 FTEs	0.0 FTEs

The average caseload per Full-Time-Equivalent (FTE) case manager was 30 to 35 active ongoing clients with an additional 30 to 35 clients on a less intensive follow-up basis in 1986.⁵⁰ In 1993 the average caseload per FTE case manager is 60 to 70 active ongoing clients with an additional 30 to 35 clients on a less intensive follow-up basis.

Costs

S/HMOs draw from an insurance risk pool established through monthly capitated payments from Medicare and

Medicaid(voluntarily enrolled Medicaid recipients), enrollees' premiums and co-payments for the expanded chronic-care benefits.⁵¹ Medicare pays S/HMOs involved in the demonstration project monthly rates set at 100 percent of what would have been spent on the members in the local fee-for-service system, as calculated in a modified version of HCFAs Adjusted Average Per Capita Costs(AAPCC) formula. Regular Medicare HMOs receive 95 percent of this formula. To compensate for the higher medical costs of community residents who are Nursing Home Certifiable(NHC) the formula has been modified to pay S/HMOs the higher institutional rate for NHCs(about double the overall average in the AAPCC), while paying slightly less for non-disabled community residents.⁵² Long-term care and other parts of the benefit package are financed by the 5 percent of AAPCC beyond what regular HMOs receive, member premiums, and the acute-care savings derived from the efficient use of hospitals participating in the S/HMO demonstration project. Providers and managers each receive a negotiated share of the pool. The cap on revenues gives managers and providers an incentive to minimize expenses. The cost of such services averaged \$35 per enrollee per month in 1986. Prescription drug benefits on average have added another \$30 to \$40 Per-Member-Per-Month(PM/PM) per S/HMO enrollee for the same period.⁵³ S/HMOs integrate the payment and management of all

home care and nursing home services whether or not these services meet Medicare or long-term care criteria.

Integration provides the incentives and the means to develop the least costly service package that is appropriate to meet patient needs. Expanded long-term care costs range between \$27 and \$30 PM/PM across the sites, slightly above Medicare costs of between \$24 and \$25 PM/PM at three of the four sites, and far above Seniors Plus Medicare costs of \$8 PM/PM.⁵⁴ At the Medicare Plus II site the original value of the chronic care benefit was \$30 per-member-per-month. This would be adequate if the proportion of members using the benefit at one time did not exceed 5 percent and if the average cost per month of a care plan for chronic care services did not exceed \$600. Not included in this capitation estimate is the cost of managing the expanded care benefit, particularly the cost of the case management/resource coordination function budgeted at \$4.50 per month at the KP site and a bit more at other S/HMO sites, where the case managers do perform utilization control and expanded case management functions.⁵⁵

HMO and S/HMO Statistics, Utilization and Costs

TABLE 5

COMPARISON - MEDICARE PLUS I AND MEDICARE PLUS II
1992 Data

CATEGORY	MEDICARE PLUS I	MEDICARE PLUS II
Monthly Premium	\$79.00	\$144.00
Av. Enrollment	38,073	4,846
Hospital Discharge days/1000	1272	1784
Mental Health Discharge days /1000	55	40
SNF Discharge days/1000	552	904
Doctors Office Visits/1000	7840	9751
Mental Health Visits/1000	n/a	118
Hearing Aid Visits/1000	n/a	28
Pharmacy Dispenses/1000	n/a	22.1
Home Health		
Visits/1000		
RN	n/a	968
Physical Therapy	n/a	277
Occ. Therapy	n/a	29
Speech Therapy	n/a	12
Social Worker	n/a	7
Home Health Aide	n/a	356
Homemaker	n/a	5
Hospice	n/a	639

Chronic Care Services percent of 1992 S/HMO

Membership

Nursing Home Certifiable(NHC)	15 percent
Members on Chronic Care Services	7.9 percent

Costs Per Member/Per Month(PM/PM) Costs

Chronic Care Cost	\$30.00
Case Management Cost	\$12.00

Targeting Expanded Care in the S/HMO Environment⁵⁶

Targeting is the process of screening and sorting the population into categories for different treatments. Targeting includes screening and assessment for making service arrangements and monitoring and counseling. The S/HMO demonstration project, by acting as a setting for targeting, has allowed for an evaluation of the decision making process for integrating acute care with expanded care services. First, the S/HMO delivers not only community-based long-term-care, but is also responsible for a full range of acute medical and nursing home services. Chronic care services must be targeted in concert with targeting physician, hospital, and skilled home health and nursing home care. Second, the S/HMO membership includes a mix of both able-bodied and frail members. The S/HMO has to deliver appropriate care to a broad mix of members. Third, the S/HMO must manage all services, including all Medicare-covered

benefits, as well as the expanded care entitlement, with a fixed budget. The S/HMO must determine how broadly and explicitly to define target groups, what services to offer them, and how intensively they can afford to serve them, given limited funds and multiple demands. Direct costs and cost offsets of both services and administration must be considered. Expanded care needs to fit into particular delivery systems and be congruent with organizational auspices and goals. Efficiency in effort spent sorting members into categories is necessary in order to satisfy management desires to keep costs within prospective budgets. Equity and effectiveness is essential in identifying target categories and assuring that similar needs receive similar treatment and dissimilar people receive dissimilar treatment and it must also be flexible enough to satisfy staff desires to meet individual patient needs. Prevention by treating impairment during early stages may yield later benefits. Marketability through appeal to the needs and desires of consumers is a prerequisite for survival. Fourth, in determining the targeting of expanded care, the S/HMO has the additional problem of defining the insurable event and deciding who should define it. As a result of having purchased health insurance, including LTC Benefits, the members have an entitlement to services. All members must be treated the same, and all have a substantial claim to

receive services in the same circumstances. Finally, although the experience of the HCFA S/HMO demonstration Project may not resolve the debate about broad versus narrow targeting, it may point to some ways out of it.

CHAPTER IV

RESULTS

This chapter presents pertinent results of the Analysis Chapter addressing health care delivery for the elderly in Riverside County.

Relevant Population

Riverside County's elderly population is widely dispersed across the county. For the sake of analysis it was broken down into three age groups, 65+, 75+ and 85+. Further graphs were developed, using 1990 census data, to help identify service areas, prioritize need, and identify high risk populations. (see Appendix A, RIVERSIDE COUNTY ELDERLY POPULATION BY COUNTY SUBDIVISION)

Needs Analysis

The "Needs Analysis" conducted by the Riverside County Area Office on Aging clearly identified not only the health care needs of the elderly, but also identified access issues, home-based care needs and community-based service needs. Table 5 matches elderly needs with S/HMO services.

TABLE 6

ELDERLY NEEDS vs. S/HMO SERVICES

ELDERLY NEEDS	S/HMO SERVICES
Transportation	Provided with caps*
Home-based Services	Provided with caps*
Home-maker	Provided with caps*
Home-delivered meals	Provided with caps*
Respite Care	Covered in full
Adult Day Care	Provided with caps*
Hospice Care	Covered in full
Long-term Care	14 days per spell * of illness

*(up to \$12,000 per year, 20 percent co-pay)

Health and Social Support for the Elderly

An important measure of health status for the elderly is the ability to perform the activities of daily living (ADL) such as walking, bathing, using the toilet, dressing, eating, and getting in and out of bed. Appendix D includes charts, created by the National Center for Health Statistics, illustrating the percent distribution of persons 65 years of age and over reporting difficulty performing activities of daily living and Instrumental activities of daily living in the 1980s. These data support the trends and projections discussed in the previous section. Aged individuals also carry a number of medical diagnoses of

various chronic conditions, most commonly arteriosclerosis, arthritis, and diabetes.⁵⁷

Alternatives

Comparisons between the two alternatives, a standard HMO TEFRA Risk Contract covering both Medicare Parts A and B and Social HMO(S/HMO) with expanded and chronic care benefits help identify those services that assist the S/HMO in reaching its goal and objective of decreasing hospital utilization, providing in-home chronic care and expanded health care services, and keeping the elderly person out of a long-term care facility.

S/HMO Model

The model described in the previous section delineates the services provided, membership mix, product line, direct costs, and the organizational structure necessary to successfully provide the necessary health care services for meeting the needs of the elderly.

S/HMO and Statistics, Utilization and Costs

The Analysis Chapter demonstrated that there are inherent problems in controlling utilization and costs primarily due to non-queuing, lack of marketing, and high monthly premium.

CHAPTER V

CONCLUSION

S/HMO Effectiveness

Can a S/HMO organization be effective in meeting the needs of Riverside County's elderly population? The answer appears to be a qualified yes. Many problems identified in the previous chapter relative to enrollment, utilization, and costs associated with integrating a S/HMO structure into a mature HMO appear to be able to be solved.

Marketing problems, lack of queuing, and high premiums have not allowed Medicare Plus II to recruit new members into the program in a manner that would keep adverse risk members at an acceptable level (< 5 percent-7 percent). The additional monthly premium has discouraged all but the high risk population from enrolling. Those in near or immediate need of long-term care support are actively enrolling but, of course, they are older and higher utilizers of health care services. The aging of the membership also increases attrition by death. This fact, along with the inability to recruit new members, has not allowed Medicare Plus II to maintain an "average risk" membership. The effectiveness of Medicare Plus II in cost effectively serving the needs of Portland's elderly population has been impacted by this inability to maintain a balanced membership. Discussions

with Lucy Nonnenkamp, Project Director for Medicare Plus II highlight this fact. Ms. Nonnenkamp comments that over 70 percent of Medicare Plus II's membership is over the age of 85. This has raised the "cost to serve" members of the S/HMO primarily due to increased hospital and outpatient utilization far beyond what was expected by HCFA. In 1992 hospital discharge Days/1000 by Medicare Plus II members exceeded Medicare Plus I members by almost 40 percent or 512 days per thousand members and Outpatient visits by Medicare Plus II members exceeded Medicare Plus I members by approximately 25 percent or 1911 visits per thousand members. Nursing Home Certifiable (NHC) members averaged 15 percent of Medicare Plus II membership in 1992. Leutz⁵⁸ makes reference to the reasons mentioned by stating that because Medicare Plus II does not queue, new members are not as likely to offset increasing disability among existing members. Nursing home certifiable members in Medicare Plus II had increased from 4 percent in 1986 to over 10 percent in 1988, and as mentioned earlier, 15 percent in 1992. The other three sites of the demonstration project have queued new applicants who were severely disabled to maintain prevalence of ADL disability at community rates and have managed to keep their NHC members at or below 7 percent of their member population.

S/HMO Services for Riverside County

In order for a S/HMO organization to be effective and successful in Riverside County it must be structured in such a way as to meet the unique needs of the county's elderly and the ability to maintain growth in membership while controlling costs related to over-utilization and adverse risk.

Demographics

As demonstrated in Appendix A Riverside County's elderly population is widely dispersed. In order to effectively serve this community the S/HMO would have to extend services out to the communities where the elderly live. This would alleviate travel concerns for the elderly and assist the S/HMO staff in building relationship with the community. This would enhance the S/HMOs ability to interface with local senior service organizations, local nursing homes, local area providers, understanding local community issues, and extending case management and expanded chronic care services into the home in a much more effective manner.

Marketing

Marketing plans for the S/HMO must include education factors and be easily understood by the elderly. Marketing

literature must educate the elderly on the major differences between the standard Medicare Risk Benefit and the extended S/HMO Benefit in a clear and concise manner. The S/HMO must utilize telemarketing, mailings, presentations at public meetings, and senior magazine advertising in an effective manner. Follow-up must be done by the S/HMO by telephone and by personal visit to ensure that the marketing approach and information was clearly understood. The S/HMO should also conduct an "Open House" on a regular basis and obtain "buy-in" and participation of senior citizen social networks, another reason to locate satellite health care centers in the local communities. "Senior Days" could also be scheduled on a regular basis to enhance the community aspect of the organization.

High Monthly Premium

With the Health Care Financing Administration (HCFA) carefully monitoring Medicare expenditures, the S/HMO must structure its premium package to maintain fair profitability. At the same time the S/HMO should not structure the plan in such a way to scare off the majority of the elderly population. One way to do this would be to "step" the premium by age group, providing three premium levels for the 65 to 74, 75 to 84, and 85+ age groups respectively.

Queuing and Membership Growth

In order to remain profitable the S/HMO needs to control "adverse risk." If too many members become nursing home certifiable or require acute care it becomes difficult to maintain profitability and increased acute care utilization. Queuing can be used effectively, without community repercussions if the membership is kept large enough to absorb at least the community average number of Nursing Home Certifiable (NHC) members. Membership growth in the Medicare Market is an important key to success. A large membership spreads the risk of high cost cases. For example, counties with smaller populations of 65 years of age or over experience nearly 2 percentage points more variation in their AAPCCs each year than the largest counties. This figure is roughly 25 percent of the annual variation for these counties although year-to-year AAPCC variation statistically tied to county population size disappears for counties with 25,000 or more people.⁵⁹

Controlling Costs and Utilization

Previous discussion on this subject indicate that all the S/HMO sites had problems controlling costs and utilization. This was primarily due to low membership, lack of integrated case management, staff education and buy-in,

and inherent problems in adequately monitoring utilization. Elderly programs require specialized staff and significant administrative activities associated with Risk contracts and large enrollments are necessary for Risk programs to be cost effective. There is also evidence that new members are lower risks than are long-term members. This suggests that continued growth and enrollment will help to maintain lower utilization levels. Management Information Systems must be developed to accurately track, on a month-to-month basis, Medicare Risk Contract revenues and expenses. Many organizations do this now on an annual basis. This needs to be done on a monthly basis so that the necessary corrective action can be taken immediately. Both out-patient and in-patient revenues and costs need to be further broken into areas of service.

Successful Risk Contracting

What does it take to be successful in Medicare Risk Contracting? Review of the literature suggest the following:

Utilization Review and Case Management Programs need to be innovative and aggressive in monitoring their delivery programs and must specifically tailor these programs to meet the needs of the elderly. Increased use of case management, geriatric assessment teams, and concurrent review should be included. As the S/HMO does, these programs need to

encourage treatment at the patient's home and strive for early discharge of the hospitalized patient. This would potentially cut costs and increase member satisfaction.

In lieu of long-term care or hospitalization increased use of "step-down" care (e.g. SNFs) suggest that some patients can be admitted directly to a SNF rather than a hospital for treatment, especially when chronic and expanded care services are being provided in the home.

Identification of the "high-risk" members as they enroll are important to both case management and the delivery program. The S/HMO, using the Comprehensive Assessment Form previously discussed, and other forms to determine NHC members helps in this process. This allows referral to the Geriatric Assessment Teams as appropriate.

The elderly use different services than other HMO members (e.g. SNF, home health, Durable Medical Equipment, and drugs), and therefore require a near separate delivery system and separate cost management tools. The S/HMO functions of the organization should be a separate line of business. Its corporate administrative structure should be primarily aligned with Medicare functions. Sales, market research, membership services, and membership accounting should also be divided along this line.

Physicians and medical staff must buy-in to special delivery systems for the elderly. In order to do this they

need adequate and on-going in-servicing related to characteristics and needs of the elderly patient. This specialized care requires more geriatric specialists, social workers, and other staff that are trained specifically to care for the elderly.

As mentioned earlier, membership growth is extremely important in order to control adverse risk and its associated high utilization. The use of "Volunteers" in administrative roles, peer counselors, and home visitors to facilitate "bonding" of the member to the Risk plan can be highly successful. The Premium charged must be carefully considered due to the fact that low premiums and low rate increases are more important to Medicare beneficiaries that are on a fixed income.

Finally, Wagner⁶⁰ suggests that a program for the care of the elderly patient needs to contain the following:

- Unanimous agreement from provider and administrative staff that the elderly present unique issues and challenges.
- Appreciation for the elderly.
- Commitment from medical and administrative staff
- Emphasis on independence, quality of life issues, and prevention of acute illness.
- Support systems and resources for providers who care for the elderly patients.

- A targeting mechanism for early identification of health and related problems.
- An integrated system that provides a continuum of care.
- Ability to expand and incorporate new growth that allows the HMOs population to remain "average."
- A good Management Information System.
- Ongoing collaborative efforts with organizations and universities specializing in geriatric efforts.
- Ability to maximally utilize community resources

More Research Required

Many of the authors of the literature reviewed felt that more research was needed in the following areas:

Kenkel⁶¹ felt that more research was required to measure and understand the following:

- 1) How well S/HMOs custodial care services reduce nursing-home costs and spending by both Medicare and Medicaid.
- 2) Expansion of S/HMOs so that researchers would have more opportunity to better understand their impact on the cost and quality of care for senior citizens in an integrated delivery system. Right now S/HMOs don't have a large enough volume of people who are in that frail category

Greenlick⁶² felt that several issues need to be resolved before chronic care services can be integrated into the growing number of HMOs that provide Medicare benefits on a risk basis, as defined by TEFRA. The most important issue is whether chronic care services can be provided within an entitlement system. Does available information support the creation of this entitlement? Some technical and policy issues still remain to be addressed. The need to determine the proper role of long-term institutional coverage within a chronic care benefit, especially one primarily designed to keep people functioning in their own homes. Medicare Plus II permanent institutionalization occurs in the ICFs. Thorough analysis of ICF patterns of use within the total utilization pattern of chronic care raised two policy questions: The first question related to the role of ICF care in maintaining a plan to keep a patient at home. It can be posited that one reason for including ICF coverage within a community-based services program is to provide an additional resource to help people stay in their own homes. During the last 6 months of the project in 1987 the ICF costs represented 47 percent of the total costs of expanded care. Placements were classified according to eight different categories of reasons for admitting. Some of the reasons for placement were required to keep people in their own homes. The observed pattern of use of institutional LTC contrasts

sharply with the patterns observed from national data regarding individuals not in S/HMOs. The observed pattern displays more frequent short-stay admissions to nursing homes, and probably, less frequent permanent placement. Rigorous conclusions are difficult because a cohort of admissions to nursing homes was not available. The second question relates to the extent that the limitation of 100 days of ICF coverage is exceeded by patients with longer stays. Researchers may want to estimate the costs of extending the benefit beyond the 100 day limit.

Harrington⁶³ felt that there were other possible reasons for higher utilization. Both Medicare Plus II and Seniors Plus experienced higher utilization than their HMO Medicare members (30 percent higher at Medicare Plus II) suggesting that their S/HMO members may have been older and more frail (possibly due to adverse selection) or that their members were aging and they were not enrolling enough young healthy members to offset the aging of members, or both. Also, because all the S/HMOs had relatively small enrollments, they were more affected by swings or increases in hospital utilization among a small number of members than would be true of larger health plans.

The overuse of specialty services, emergency room services, and hospitalization was a problem at the S/HMOs with long-term-care organizational sponsors. Pharmacy

utilization was also a problem for all the S/HMOs. A pharmacy capitation contract was established at \$38 PM/PM at Elderplan and at \$23 PM/PM at SCAN in 1989.

Generally, the financial problems at the S/HMOs were related to higher than expected acute-care utilization and costs, as well as high marketing and administrative costs (at three sites), rather than problems with chronic-care utilization and costs.

Leutz⁶⁴ identified three issues for further study. First, identify and study differences in the intensity of Case Management Services. There were two models, the hand-on approach of the service manager and even the service giver; and the benefits manager approach, in which case managers are assessors, authorizers, and coordinators. Second, compare who receives care and how much they receive with a goal to improve management practices, efficiency, and effectiveness through case management models that produce benefit levels commensurate with need. Third, improve understanding of the informal caregiver process and to find ways for enhancing informal care giving and improving the joint decision-making process among case managers, frail members, and informal supporters.

Leutz also feels that several other points stand out:⁶⁵ First, the S/HMO share a relatively uniform and effective system of screening and assessing the new members. The

system collects a uniform database on all members. Second, the S/HMOs use different eligibility criteria for expanded care and some serve larger proportions of their memberships. Third, targeting systems for able-bodied members who become impaired have been developed to fit each sites service system. Fourth, boundaries between Medicare and expanded care benefits must be defined and managed, and finally, several areas that have been only touched on will be addressed in future development efforts and research on the S/HMO.

Kenkel⁶⁶ felt that more research was needed to first measure how well S/HMOs custodial care services reduce nursing-home costs and spending by both Medicare and Medicaid, and second, expansion of S/HMO program would give researchers more opportunity to better understand their impact on the cost and quality of care for senior citizens in an integrated delivery system. Right now S/HMOs don't have a large enough volume of members who are in that frail category.

Congressional Activity

In 1993 Congress included funding for a provision to extend the S/HMO program through 1997. About \$95 million in federal money is paid to the S/HMOs annually. Besides authorizing each S/HMO to enroll as many as 12,000 people,

nearly double the number for which they're currently authorized, Congress also told HCFA to solicit bids for four new sites. If the new sites are launched successfully, S/HMOs should become a permanent fixture in Medicare's managed-care programs by 1998 or 1999.....⁶⁷ The success of the S/HMO model presents policy makers with an opportunity to give millions of beneficiaries access to virtually all of the Act's acute-care protection plus significant new benefits for community-based long-term care.

Summary

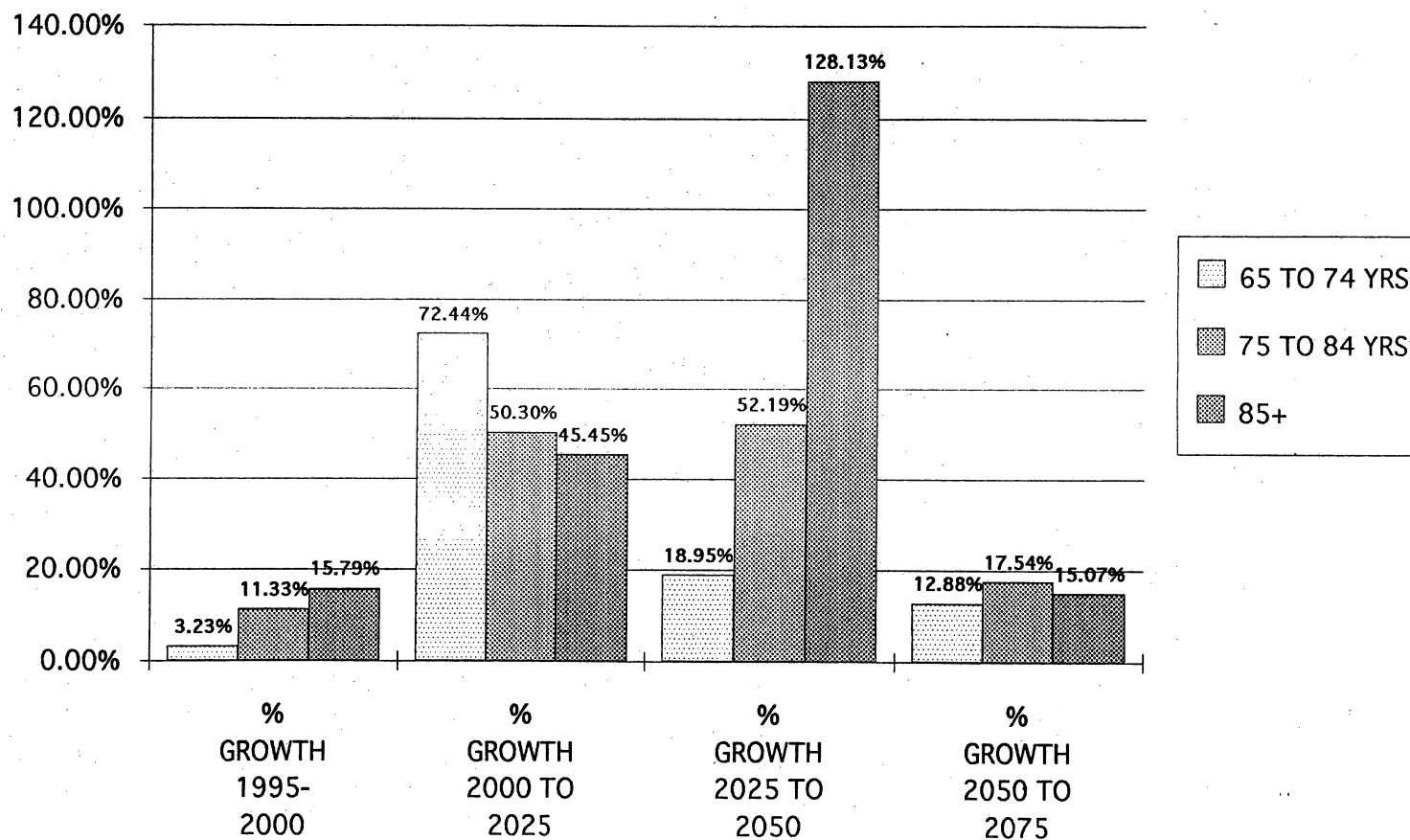
In summary, it appears that a Social HMO, structured as described in conjunction with an existing HMO, has the potential for meeting the needs of Riverside County's elderly. It also has the potential for decreasing hospital utilization and the cost-to-serve if "adverse risk" members are kept to an acceptable level. The S/HMO demonstration also provides evidence that chronic care services can be provided with an entitlement system, under the constraints of predetermined budgets. It demonstrates that these benefits, when delivered in an HMO-like setting, can be an attractive alternative to long-term care insurance. It also demonstrates that by using ICFs, long-term care admissions can be kept at an acceptable level for elderly members. This not only keeps the elderly member at home but provides some

financial protection against the costs of long-term care for the elderly member.

APPENDIX A

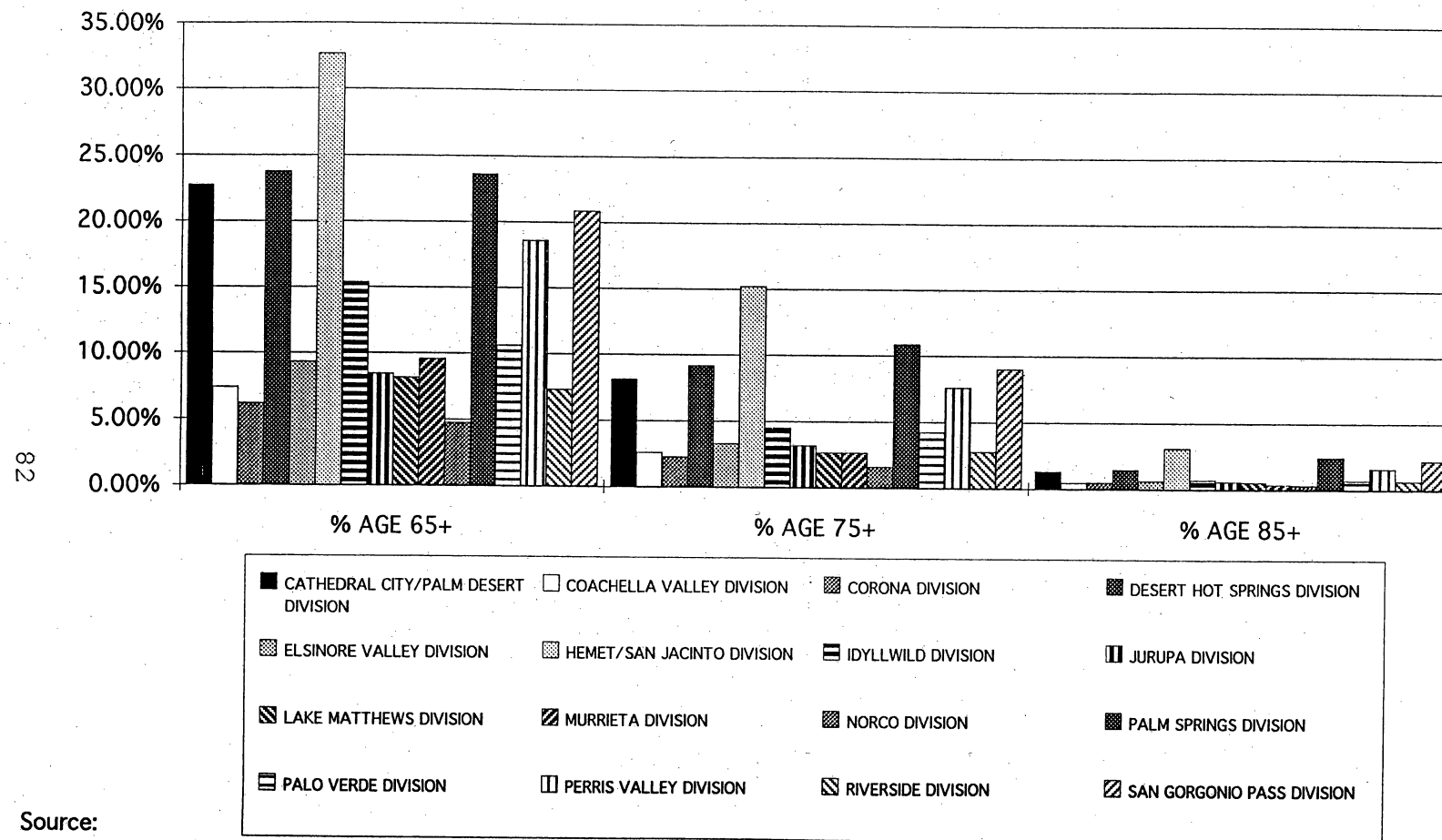
Elderly Population Distribution

65+ Population Projection(National): 1995 - 2075



Source: Social Security Admin., Office of Programs, 1990 Census

RIVERSIDE COUNTY ELDERLY POPULATION BY COUNTY SUBDIVISION

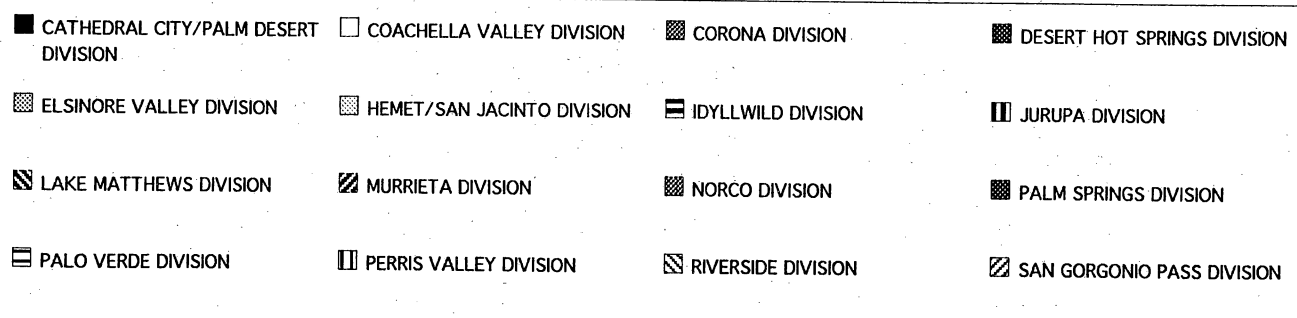
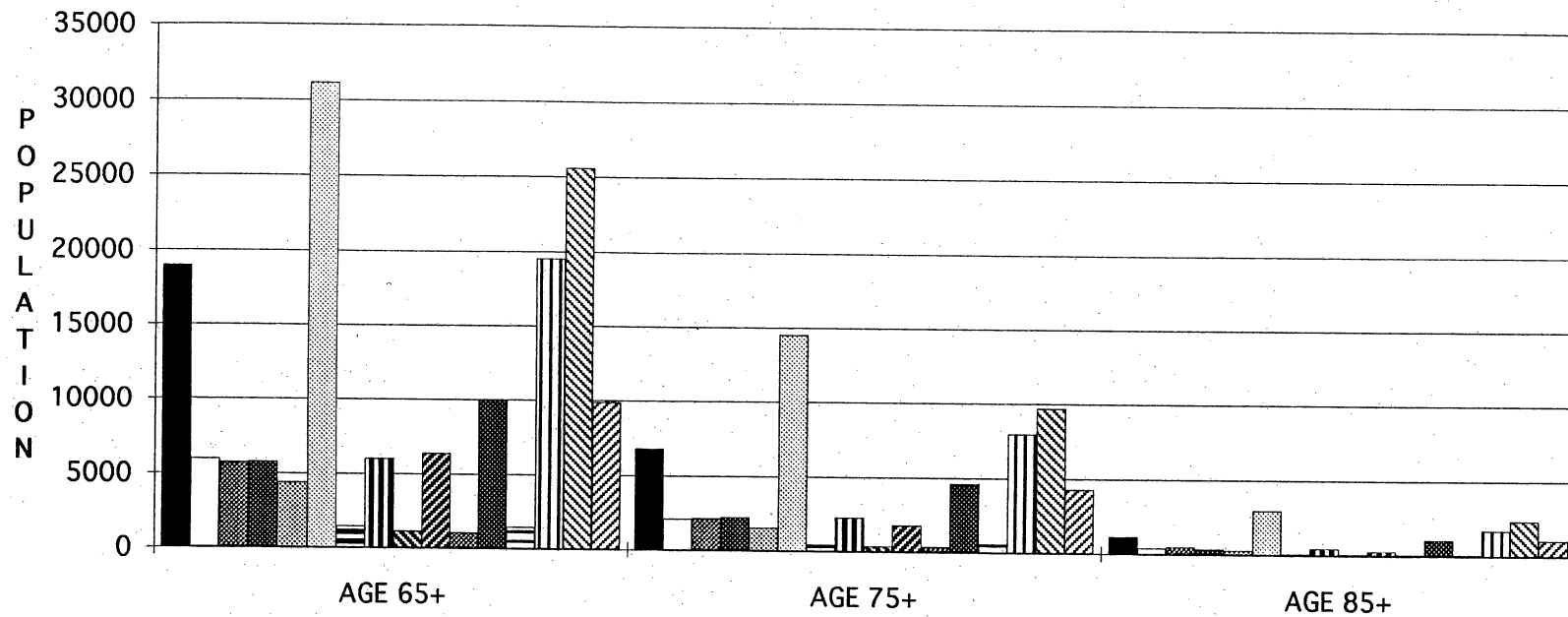


Source:

1990 Census of Population and Housing
1990 CPH-1-6
Bureau of the Census

(ELDERLY AS % OF OVERALL POPULATION)

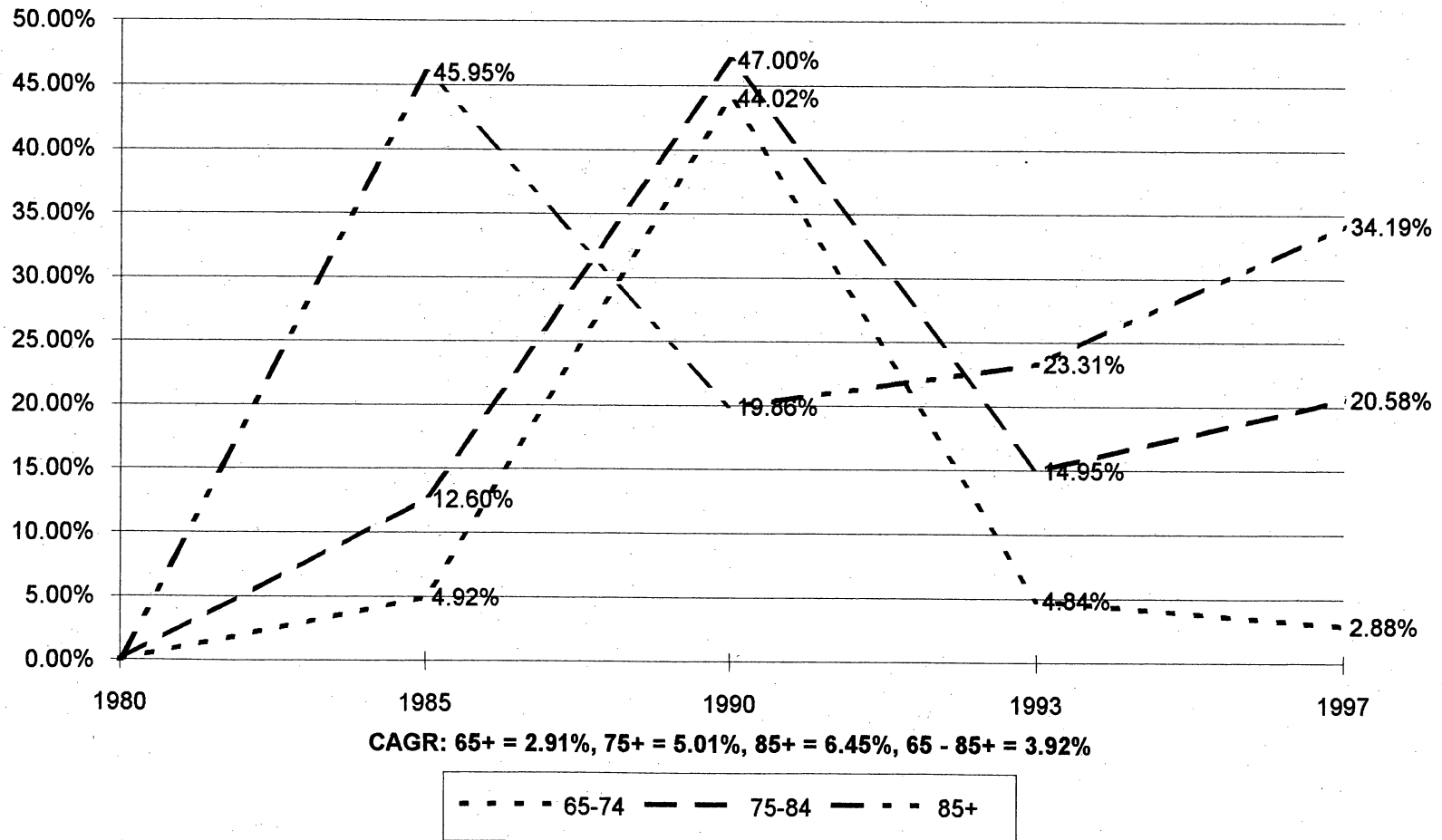
RIVERSIDE COUNTY ELDERLY POPULATION BY COUNTY SUBDIVISION



Source:

1990 Census of Population and Housing
1990 CPH-1-6
Bureau of the Census

Riverside County 65+ population growth: 1980 - 1997



Source: California State Dept. of Finance,
Demographics Unit

2/1/94

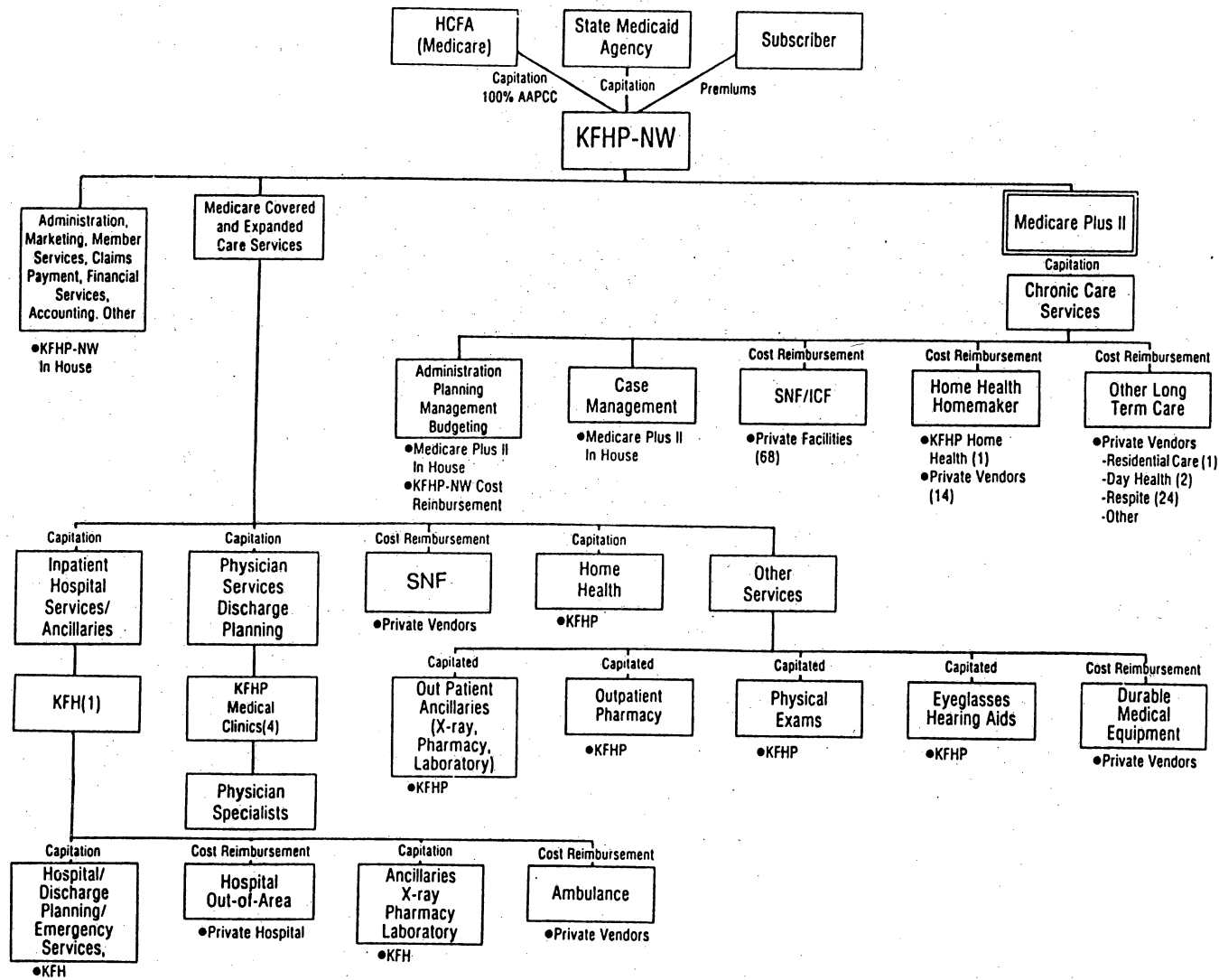
APPENDIX B

Medicare Plus II Organizational Chart

(Source: Report to Congress: Evaluation of the Social/Health Maintenance Organization Demonstration, HCFA Pub. NO. 03283)

Figure 1

Kaiser Medicare Plus II Service Delivery System and Method of Payment — 1987



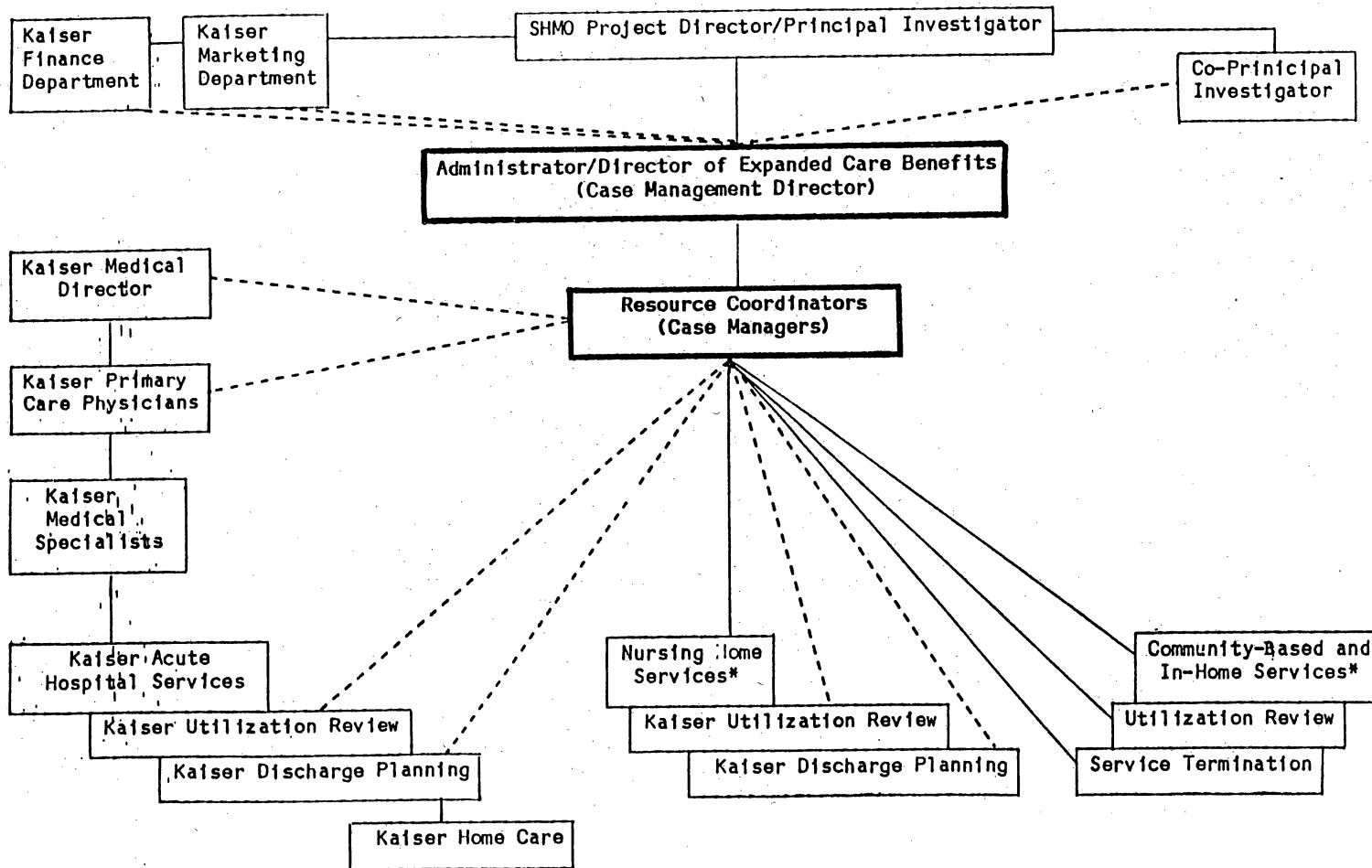
APPENDIX C

Medicare Plus II Case Management Linkage

(Source: Report to Congress: Evaluation of the Social/Health Maintenance Organization Demonstration, HCFA Pub. NO. 03283)

Figure 3

CASE MANAGEMENT LINKAGES WITH THE S/HMO DELIVERY SYSTEM: MEDICARE PLUS II



KEY:
 Direct Control _____
 Coordination - - - - -
 Contracted Services *

APPENDIX D

The Elderly: Reported Difficulties Performing ADLs

(Source: Vital and Health Statistics, Chart book on Health Data on Older Americans: United States, 1992. U.S. Dept. of Health and Human Services, Series 3, No. 29)

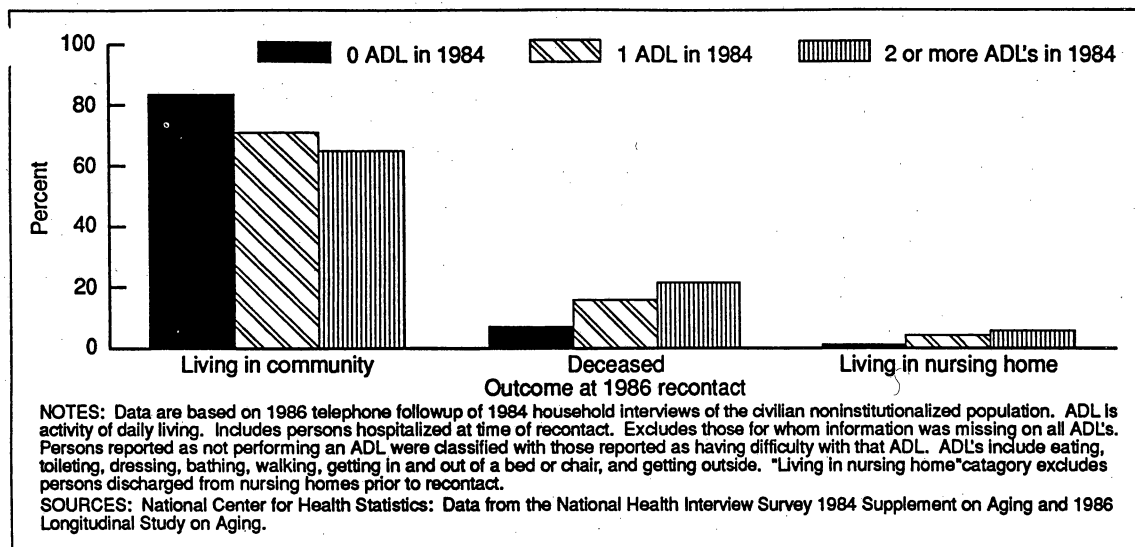


Figure 11. Percent distribution of persons 70 years of age and over in 1984, according to outcome at 1986 recontact and number of activities of daily living for which difficulty was reported in 1984: United States

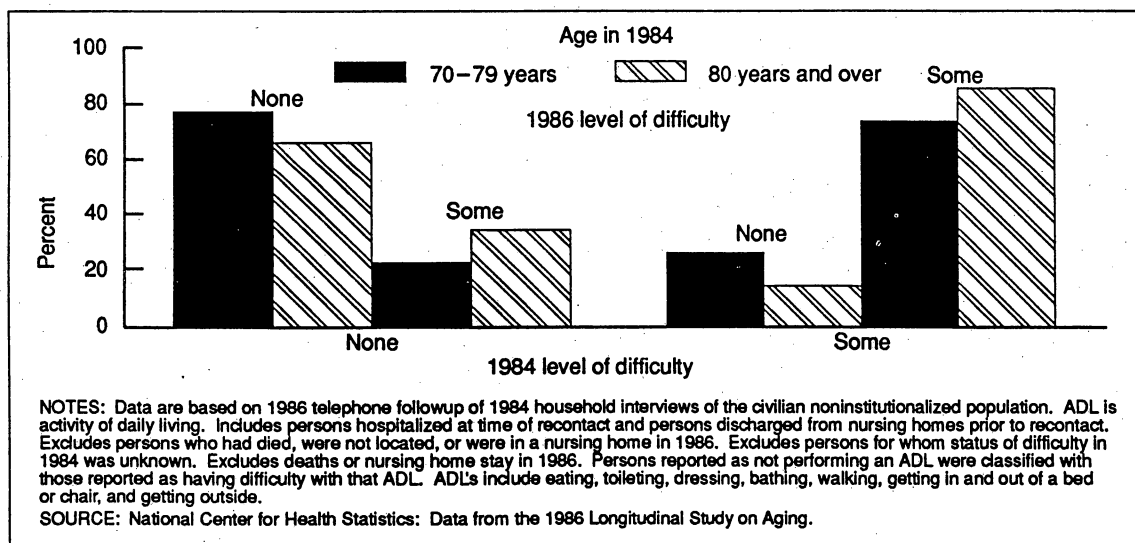


Figure 12. Percent distribution of persons 70 years of age and over, according to age and extent of difficulty in performing activities of daily living in 1984 and at 1986 recontact for those living in the community between 1984 and 1986: United States

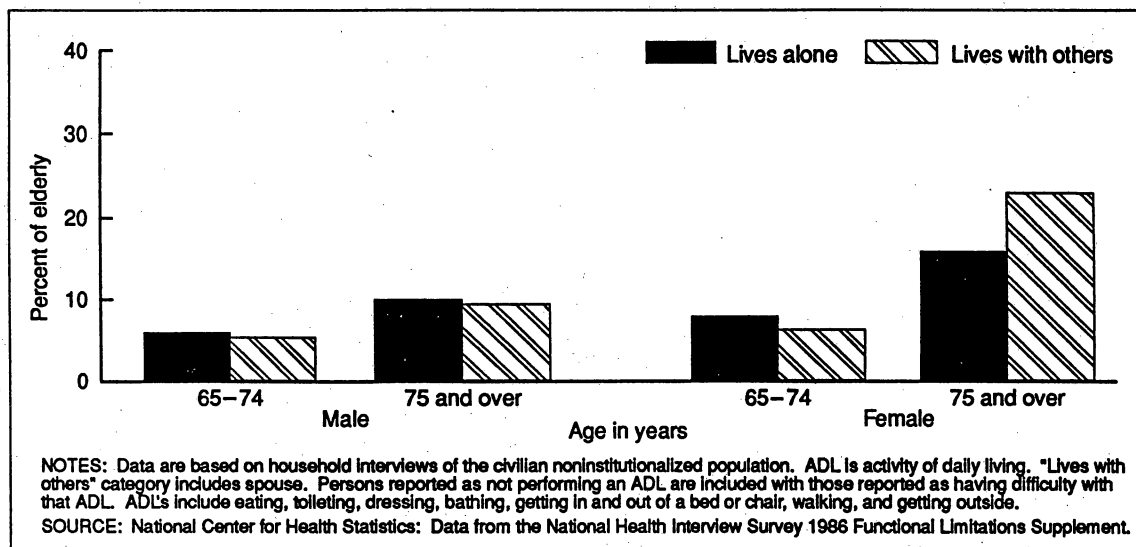


Figure 7. Percent of persons 65 years of age and over reporting difficulty performing three or more activities of daily living, by living arrangement, sex, and age: United States, 1986

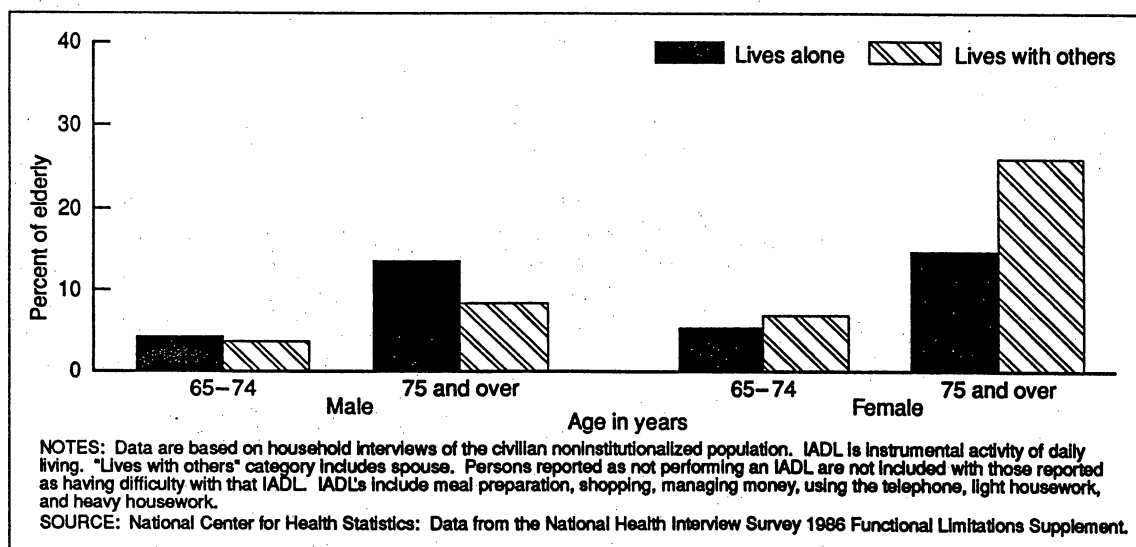


Figure 8. Percent of persons 65 years of age and over reporting difficulty performing three or more instrumental activities of daily living, by living arrangement, sex, and age: United States, 1986

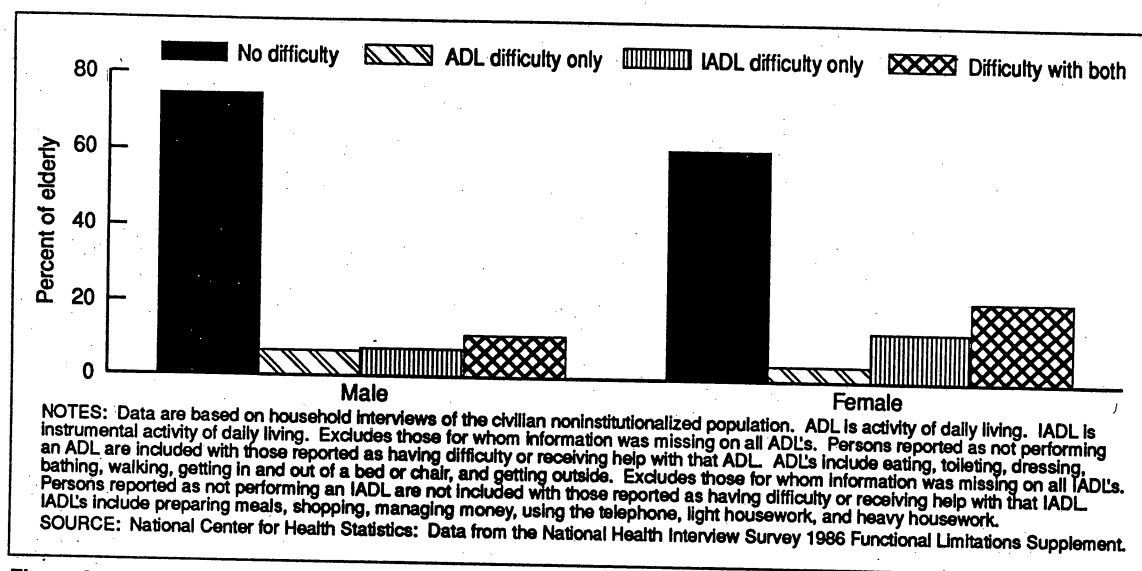


Figure 9. Percent distribution of persons 65 years of age and over reporting difficulty performing activities of daily living and instrumental activities of daily living, according to sex: United States, 1986

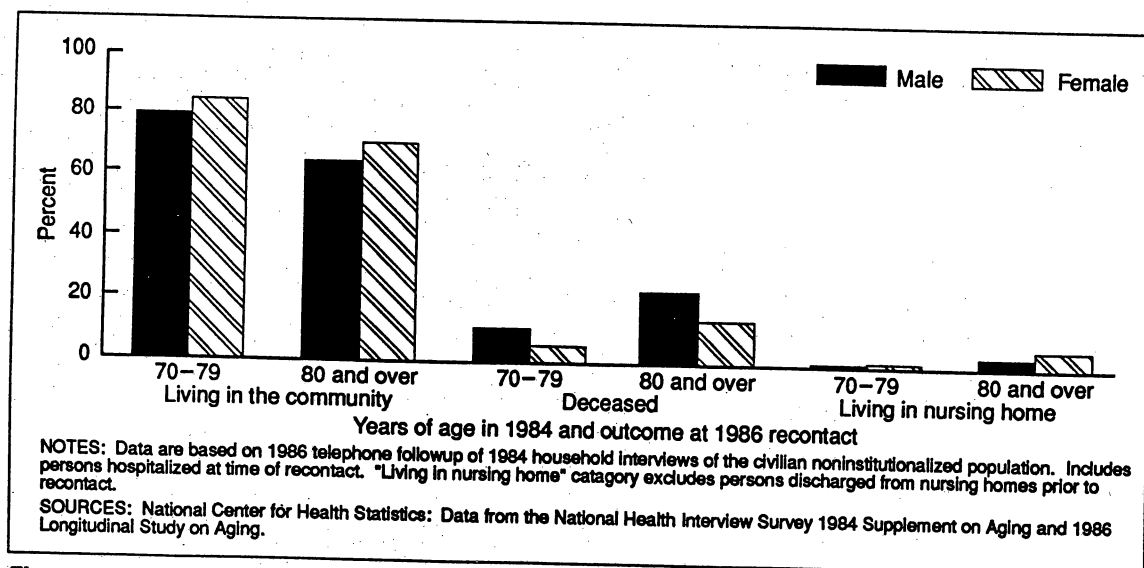


Figure 10. Percent distribution of persons 70 years of age and over in 1984, according to outcome at 1986 recontact, age, and sex: United States

APPENDIX E

Research Consortiums Comprehensive Assessment Form (CAF)



(1)

KAISER PERMANENTE**CONFIDENTIAL**

INITIAL H&F

MEDICARE PLUS II

Please help us plan for your health care by answering these questions and returning the questionnaire to us in the enclosed envelope.

DIRECTIONS: Complete this form by filling in the appropriate information in the spaces or boxes provided. Unless otherwise indicated, select the one answer that fits you best and mark an (X) in the box.

	_____	2
	Health Record Number	
1. NAME	_____	3
	Last First Middle Initial	4
		5
2. ADDRESS	_____	6
	Number Street Apartment No.	
	_____	7
	City/Town State Zip Code	8
3. TELEPHONE ()	()	9
	Area Code Home Area Code Office	10
4. IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?		
	_____	11
	Name Relationship	12
		13
	_____	14
	Address City, State Zip	15
	_____	16
	Telephone: Day Night	17

5. Are you currently taking any medications?

(2)
Yes ☐ 1 11
No ☐ 2

6. List prescriptions and medicines you are currently taking.

19

Medications

For what health conditions
do you take this medication?

20

21

7. Compared to other persons your age, would you say your health is: (Check one)

22

Excellent . ☐ 1
Good ☐ 2
Fair ☐ 3
Poor ☐ 4

8. Do you regularly receive any of the following special treatments? (Check all that apply)

	Yes	No	
(a) Injections.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	23
(b) Oxygen	<input type="checkbox"/> 1	<input type="checkbox"/> 2	24
(c) Changing of bandages .	<input type="checkbox"/> 1	<input type="checkbox"/> 2	25
(d) Tube feedings.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	26
(e) Tracheostomy care....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	27
(f) Ostomy care.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	28
(g) Catheter care	<input type="checkbox"/> 1	<input type="checkbox"/> 2	29
(h) Chemotherapy	<input type="checkbox"/> 1	<input type="checkbox"/> 2	30
(i) Other (Describe):	<input type="checkbox"/> 1	<input type="checkbox"/> 2	31

32

33

9. Prior to enrollment in this health plan, did you have a physician or a particular medical clinic you went to for routine health problems?

10. IF YES, please complete information below:

Name of regular physician or medical clinic _____ Telephone _____

Street _____ City _____ State, Zip _____

11. Do you have any of the following health conditions? (Check NO if you do not have the health condition)

	Yes	No	
(a) Diabetes (high blood sugar disease) .	<input type="checkbox"/> 1	<input type="checkbox"/> 2	35
(b) High blood pressure	<input type="checkbox"/> 1	<input type="checkbox"/> 2	36
(c) Heart trouble	<input type="checkbox"/> 1	<input type="checkbox"/> 2	37
(d) Stroke	<input type="checkbox"/> 1	<input type="checkbox"/> 2	38
(e) Lung/breathing problems	<input type="checkbox"/> 1	<input type="checkbox"/> 2	39
(f) Chronic cough	<input type="checkbox"/> 1	<input type="checkbox"/> 2	40
(g) Cancer	<input type="checkbox"/> 1	<input type="checkbox"/> 2	41
(h) Circulation problems	<input type="checkbox"/> 1	<input type="checkbox"/> 2	42
(i) Stomach/bowel problems	<input type="checkbox"/> 1	<input type="checkbox"/> 2	43
(j) Urinary problems (bladder)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	44
(k) Other health conditions (describe):	<input type="checkbox"/> 1	<input type="checkbox"/> 2	45

_____ 46

_____ 47

12. Are any of these conditions getting worse?
IF YES, which ones are getting worse?

Yes ☐ 1 48
No ☐ 2

_____ 49

_____ 50

13. Do any of your health conditions interfere with your daily activities?
IF YES, please explain:

Yes ☐ 1 51
No ☐ 2

_____ 52

_____ 53

14. WHICH OF THE FOLLOWING STATEMENTS FITS YOU BEST IN TERMS OF HEALTH? (Read all statements before answering—check only one box)

(a) Must stay in bed all or most of the time	<input type="checkbox"/> 1	54
(b) Must stay in the house all or most of the time	<input type="checkbox"/> 2	
(c) Need the help of another person in getting around inside or outside the house	<input type="checkbox"/> 3	
(d) Need the help of some special aid, such as a cane or wheelchair, in getting around inside or outside the house	<input type="checkbox"/> 4	
(e) Do not need the help of another person or a special aid but have trouble in getting around freely	<input type="checkbox"/> 5	
(f) Not limited in any of these ways	<input type="checkbox"/> 6	

15. During the past 12 months, how many times were you admitted as a patient in a hospital? (Check one box)

None ☐ 1 55
 Once ☐ 2
 2-3 times ☐ 3
 More than 3 times . ☐ 4

16. For what condition(s) were you in the hospital?

_____ 56
 _____ 57

17. During the past 6 months, how many separate times did you use an emergency room at a hospital?

None ☐ 1 58
 Once ☐ 2
 2-3 times ☐ 3
 4-6 times ☐ 4
 More than 6 times . ☐ 5

18. In the past 6 months, how many times did you visit a medical doctor or clinic (not counting hospital or emergency room care?) (Check one box)

None ☐ 1 59
 Once ☐ 2
 2-3 times ☐ 3
 4-6 times ☐ 4
 More than 6 times . ☐ 5

19. During the past 12 months, were you in a nursing home or convalescent home?

Yes ☐ 1 60
 No ☐ 2

20. IF YES, for what reason(s) were you in the nursing home?

_____ 61
 _____ 62

22. BECAUSE OF A DISABILITY OR HEALTH PROBLEM, do you need or receive help from another person for any of the following activities? (Check all boxes that apply) Check the "NO" box if no help is needed.

I receive or need help of another person:

	NO	SOME OF THE TIME	MOST OF THE TIME	
(a) Using the toilet in the bathroom .	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	64
(b) Bathing, including sponge baths..	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	65
(c) Dressing.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	66
(d) Eating.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	67
(e) Getting in/out of bed or chairs ...	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	68

23. BECAUSE OF A DISABILITY OR HEALTH PROBLEM, do you receive or need help from another person for the following activities? (Check all boxes that apply) NOTE: Even if someone else usually does these tasks, are you physically able to do them by yourself?

Activities	Receive/Need Help		
	Yes	No	
(a) Preparing meal.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	69
(b) Shopping for groceries, etc.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	70
(c) Doing routine household chores.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	71
(d) Managing money.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	72
(e) Doing laundry.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	73
(f) Taking medications.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	74
(g) Getting to places out of walking distance .	<input type="checkbox"/> 1	<input type="checkbox"/> 2	75
(h) Using the telephone	<input type="checkbox"/> 1	<input type="checkbox"/> 2	76

24. If you receive help with any of the above activities (question 22 or 23) who are your helpers? (Give their name and relationship, e.g. daughter, spouse, etc.)

Name _____ Relationship _____ 77

Name _____ Relationship _____ 78

25. BECAUSE OF A DISABILITY OR HEALTH PROBLEM, do you use any of the following special equipment? (Check all boxes that apply)

	Yes	No	
(a) Wheelchair	<input type="checkbox"/> 1	<input type="checkbox"/> 2	80
(b) Walker	<input type="checkbox"/> 1	<input type="checkbox"/> 2	81
(c) Cane	<input type="checkbox"/> 1	<input type="checkbox"/> 2	82
(d) Grab bars	<input type="checkbox"/> 1	<input type="checkbox"/> 2	83
(e) Bath bench	<input type="checkbox"/> 1	<input type="checkbox"/> 2	84
(f) Hoyer lift.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	85
(g) Bedside commode..	<input type="checkbox"/> 1	<input type="checkbox"/> 2	86
(h) Hospital bed	<input type="checkbox"/> 1	<input type="checkbox"/> 2	87
(i) Ramps	<input type="checkbox"/> 1	<input type="checkbox"/> 2	88
(j) Oxygen equipment .	<input type="checkbox"/> 1	<input type="checkbox"/> 2	89
(k) Other (describe):	<input type="checkbox"/> 1	<input type="checkbox"/> 2	90

26. Are you currently receiving any of the following services from an agency? (Check all boxes that apply)

	Receive Help From Agency		
	Yes	No	
Visiting Nurse	<input type="checkbox"/> 1	<input type="checkbox"/> 2	93
Therapist (Physical, Occupational, Speech) ..	<input type="checkbox"/> 1	<input type="checkbox"/> 2	94
Homemaker/Home Health Aide	<input type="checkbox"/> 1	<input type="checkbox"/> 2	95
Social Worker	<input type="checkbox"/> 1	<input type="checkbox"/> 2	96
Adult Day Health Center	<input type="checkbox"/> 1	<input type="checkbox"/> 2	97
Assistance with Transportation	<input type="checkbox"/> 1	<input type="checkbox"/> 2	98
Other (explain):	<input type="checkbox"/> 1	<input type="checkbox"/> 2	99
<hr/>			100
<hr/>			

27. Do you smoke cigarettes?

Yes ☐ 1 101
No ☐ 2

IF YES, how many cigarettes per day? _____ 102

28. Do you drink alcoholic beverages?

Never ☐ 1 103
Occasionally . ☐ 2
Frequently... ☐ 3
Daily..... ☐ 4

29. During the past 12 months, have you attempted to do any of the following:

	YES	NO	NOT NECESSARY	
(a) Lose weight	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	104
(b) Quit smoking	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	105
(c) Reduce alcohol intake .	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	106
(d) Increase exercise	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	107
(e) Other (specify): _____				108

30. How many living children do you have? _____

109

31. What is your current living arrangement? (Check each box that applies)

Live alone ☐ 110
With spouse ☐ 111
With child(ren) ☐ 112
With other relative(s). ☐ 113
With non-relative(s)... ☐ 114

32. What type of housing do you live in?

- I live in my own residence (house, condominium, apartment, mobile home). ☐ 1 115
 I live in the residence of a friend or relative ☐ 2
 I live in senior citizen housing. ☐ 3
 I live in a group home, foster care, or board and care home ☐ 4
 I live in a nursing home ☐ 5
 Other _____ ☐ 6

33. Do you own your residence (house, condominium, mobile home)?

- Yes ☐ 1 116
 No ☐ 2

34. Do you now care for a disabled person?

- Yes ☐ 1 117
 No ☐ 2

What is your relationship to the disabled person? _____ 118

35. Does that disabled person live with you?

- Yes ☐ 1 119
 No ☐ 2

36. When were you born?

_____ 120
 Mo./Day/Year 121
 122

37. What is your sex?

- Male ... ☐ 1 123
 Female . ☐ 2

38. What is your current marital status?

- Married ☐ 1 124
 Widowed ☐ 2
 Divorced ☐ 3
 Separated ☐ 4
 Never married. ☐ 5

39. What is the highest level of education you have completed? (Check one)

125

- Grade school ☐ 1
 Some high school ☐ 2
 High school graduate.. ☐ 3
 Some college ☐ 4
 College graduate..... ☐ 5

40. Below is a list of annual income groups. Which group comes closest to the total amount of your household income? This includes income of each person in the household, including social security, pensions, rent from property, dividends, interest, earned income, help from relatives and any other income. (Check one box)

Under \$3,000 per annum .	<input type="checkbox"/> 1	126
\$3,000-\$5,999	<input type="checkbox"/> 2	
\$6,000-\$9,999	<input type="checkbox"/> 3	
\$10,000-\$14,999	<input type="checkbox"/> 4	
\$15,000-\$24,999	<input type="checkbox"/> 5	
\$25,000 and over	<input type="checkbox"/> 6	

41. Do you receive Supplemental Security Income (SSI)

Yes	<input type="checkbox"/> 1	127
No	<input type="checkbox"/> 2	

42. Is there anything else you would like us to know about you?

128

43. Did you receive help in filling out this form?

Yes	<input type="checkbox"/> 1	129
No	<input type="checkbox"/> 2	

44. IF YES, what is the name, relationship, daytime phone and address of your helper?

Name	Relationship	Daytime Phone Number
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130

THANK YOU FOR YOUR COOPERATION IN COMPLETING THIS FORM

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